

**Professional Socialisation and Identity Formation**  
**in Rural Health Education**

**by**

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**submitted in fulfilment of the**  
**requirements for the Degree of**  
**Doctor of Philosophy**

**University of Tasmania**

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## STATEMENT OF ORIGINALITY

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## ABSTRACT

The study offers a critical theoretical consideration of underlying perspectives informing rural health education in an undergraduate nursing, medical and pharmacy program. A new research approach was developed and tested for examining the effects of different individuals and groups (from academics to rural health practitioners to undergraduate nursing, medical and pharmacy students) using different patterns of language in the socialising process of rural health education. The thesis describes and demonstrates the use of critical discourse analysis as a means of facilitating critical awareness and stimulating research practice focussing on rural health education. Critical discourse analysis applies to a range of semiotic methods for examining text, such as natural instances of written and spoken language, with the objective of gaining insights into the meanings of a text and what it signifies. Emphasis is placed on the way individuals and groups use language, where texts construct the social world and influence the way identity is formed.

The study builds on and contributes to work in rural health education by specifically focussing on the practice of rural health education in the undergraduate nursing, medical and pharmacy programs at a university participating in this study. Although studies in this area have examined the predictive factors that might attract students to rural practice and described various education models, there has not been research into rural health education as a process of professional socialisation. The study provides additional insight

into drivers for students' adaptation to rural culture and the role health science academics and health professionals play in rural health education as socialising agents. Although numerous studies have studied students' satisfaction with their rural learning experiences, academic performance and claims of rural intentionality, little analytic attention has been paid to identifying other unassumed outcomes of rural health education. In this study, the analytic focus on students' personal and professional identity formation as an outcome of rural health education enables another contribution.

The study findings indicate that different groups construct rural health education in different ways, for different purposes to serve different interests. From this study it was concluded that the pedagogical space for rural health education in the undergraduate nursing, medical and pharmacy programs is a contested site. Findings shows the body of knowledge known as rural health, within the undergraduate nursing, medical and pharmacy programs at the participating university was found to be ill defined. The way individuals and groups know rural health education is always mediated by and through language. Thus, the meanings and interpretations available to them about its purpose, or even the nature of rural communities, are never transparent or neutral representations. In this study, these representations tended to construct rural communities within deficit understandings. Whether constructed as a rural health workforce supply strategy or a component of the generalist core curriculum, these rural deficit understandings had significance for students' socialising experiences

and the way they shaped their personal and professional identities.

The findings suggested in this thesis are intended to trigger subsequent research into the study of language in use and meaning-making within the day-to-day practice of rural health education. Language use in rural health education appears to play a central role in enabling or constraining the goal of attracting students to rural practice as a viable career option. It is therefore important that researchers within the discipline of rural health critically examine many of the concepts and constructs that have to date been largely taken for granted.

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## TERMS USED IN THIS THESIS

Term	Usage
Boundary	A metaphoric indication of the limits of particular branches of knowledge and social practices.
Boundary Work	A set of differentiating activities that attribute selected characteristics to particular branches of knowledge on the basis of differing methods, values, stocks of knowledge, and styles of organisation.

Discourse	<p>A set of rules or constraints that make certain statements, and not others, possible in particular historical, social, and institutional contexts. More formally stated, it is “the multiple and competing sets of ideas and metaphors that embrace both text and practice” (Sharp &amp; Richardson, 2001, p 196).</p> <p>“[A] specific ensemble of ideas, concepts, and categorisations that are produced, reproduced and transformed in a particular set of practices through which meaning is given to physical and social realities” (Hajer, 1995, p 44).</p>
Governance	<p>“[T]he process through which contemporary practices of governing take place” (Dillon &amp; Valentine, 2002, p 6)</p>
Hidden Curriculum	<p>“... that set of implicit messages relating to knowledge, values, norms of behaviour and attitudes that learners experience in and through educational processes. These messages may be contradictory, non-linear and punctuational and each learner mediates the message in her/his own way”.</p>
Identity	<p>A multidimensional set of categories that define sense of self, which are culturally and historically produced in relation to the available cultural texts</p>

Ideology	<p>“[The] value of belief systems accepted as fact or truth by some group” (Lotz, 1998). This can be understood as “an exercise of power through the manufacture of consent to or at least acquiescence towards’ the uncritical use of language” (Fairclough, 1984, p 4).</p>
Pedagogy	<p>“[A] deliberate attempt to influence how and what knowledge and identities [sic] are produced within and among particular sets of social relations” (Giroux &amp; Simon, 1989, p 239).</p>
Pedagogical Space	<p>A metaphorical site in which the production of contested meanings and social practices are constituted in terms of what is appropriate or inappropriate to advance a particular interest.</p>

Power	<p>Power is a key concept used for examining rural health education in this research. The theoretical understandings of power are draw from the writings of Foucault (1972, 1973, 1975, 1979, 1980, 1988, 1991, 1994). His main points on power are that:</p> <ul style="list-style-type: none"> <li>• the most forceful types of power arises from the multitudinous, usually taken-for-granted rules that govern everyday social interactions;</li> <li>• there is an intricate network of rules that constitute the mechanisms of power;</li> <li>• power can therefore mold the thoughts and actions of people;</li> <li>• the analysis of power is best examined at the ground level - the everyday influences that affect people in their daily lives, and therefore,</li> <li>• practices, not intentions, must be the subject of study.</li> </ul>
Professional Identity	<p>The relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role (Schein, 1978).</p>
Professional Socialisation	<p>“... a subconscious process whereby individuals internalise behavioral norms and standards and form a sense of self and commitment to a professional field (Weidman, Twale and Stein, 2001, p 6).</p>



Social Constructionism	<p>“... seeks to explain the process by which knowledge is created and assumed as reality” (Berger &amp; Luckmann, 1966). The basic contention of social construction theory is that meaning is created through social interactions.</p>
Socialisation	<p>“[A]n interpretative process involved in the creation of- rather than the transmittal of meaning” (Tierney, 1997, p 6).</p>

## CHAPTER 1 INTRODUCTION TO THE RESEARCH

### INTRODUCTION

The success and sustainability of rural health education as a rural workforce preparation and supply strategy is crucial for redressing the inequities in health and health service accessibility in rural Australia. At present many schools of nursing, pharmacy and medicine are developing and implementing innovative rural health education initiatives in their undergraduate programs. The collective goal of these activities is to encourage nursing, medical and pharmacy graduates to consider rural practice as a positive career option. Ongoing monetary support from the Commonwealth government to sustain such activities will no doubt be contingent on evidence of a stronger rural health workforce. Measuring rural health workforce recruitment as an outcome, however, is being challenged by the long time it takes for students to move through their education programs and become established as health professionals. There is an urgent need to develop ways of generating understanding about the nature of rural health education, and its immediate outcomes, for its future development and sustainability as a successful rural workforce supply strategy.

The aim of this research was to describe and interpret how health science academics, rural health practitioners and undergraduate nursing, pharmacy and

medical students<sup>1</sup> produce and make sense of different meanings in rural health education and consider how students' identities are shaped by these meanings. Such research is important because although there is an abundance of literature discussing rural health education, there is very little conceptual detail about curriculum content or outcomes other than students' claims of rural intentionality. Nevertheless, schools of nursing, medicine and pharmacy are increasingly relying on rural health education as a rural health workforce supply strategy. It is a strategy that relies upon placing all learning about rural health in its overall context of rurality.

Rural health education is characterised by inherent contradiction and inconsistency for students learning in context. Learning in the rural context is acknowledged as a crucial way of generating students in a rural career (Snadden, 2006). Despite acknowledging the importance of rural context in curriculum design (Hays & SenGupta, 2003), in Australia the majority of students learning tends to occur in urban based university settings<sup>2</sup>. Most undergraduate nursing, medical and pharmacy programs are preparing students' for generalist<sup>3</sup> health

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<sup>1</sup> Herein known as academics, practitioners and students.

<sup>2</sup> The urbancentric perspective in health science education in Australia was acknowledged by educationalists, researchers and bureaucrats in the late 1990s. Since then the Commonwealth government has invested in establishing a national network of Rural Clinical Schools and University Departments of Rural Health. These Schools and Departments provide undergraduate health science students with more opportunities to study in areas (see page 273 for a more detailed discussion of Commonwealth funded programs that advance and support rural health education). Despite this national infrastructure, the majority of undergraduate health science education remains in urban locations and tends to rely on curricula oriented with urban perspective.

<sup>3</sup> A generalist health professional has a broad range of knowledge and skills for general health service delivery, and the proficient provision of care across the lifespan and in different

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professional careers. Conversely, educationalists and researchers have been working hard to define rural health as a specialty field for some time now (Crooks, 2004; Hegney, 1997; MacLellan & Que, 2001; McDonough et al., 1992; Strasser, 1995; Wronski, 2003). The resulting dialectic of contradictions raises an important question about how rural health education is being constructed and used by individuals in the undergraduate programs. And, whether it is really producing undergraduate students who are interested in rural careers.

In this research, it is suggested that within the undergraduate nursing, medical and pharmacy programs in one Australian university<sup>4</sup>, different groups (specifically academics, practitioners and students) construct rural health education in different ways to advance their own ideological interests. Consequently, there does not appear to be a body of knowledge known as rural health. The literature review shows rural health educators, researchers and government tend to construct rural health education as a rural health workforce supply strategy (chapter 2). Instead, academics and practitioners, in this study, reconfigured rural health education as a context from which students can professionally develop as generalist health professionals. In the absence of a clearly defined body of knowledge three practices seemed to emerge.

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contexts . Refer to: **National Nursing and Nursing Education Taskforce** (2006), 'Specialisation and Advanced Practice Discussion Paper', Available online at <http://www.nnnet.gov.au>, Accessed June 2007.

<sup>4</sup> The participating university will not be disclosed in order to maintain the anonymity of the research participants. Refer to page 2193 for further discussion of the ethical considerations in this study.

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First, academics tended to rely on popularist cultural representations that construct rural communities with a deficit model, which is discussed in chapter 5. These patterns of language use constructed rural communities as the medicalised other. Furthermore, the ambiguous talk of rural difference and disadvantage created a hidden curriculum that suggested rural communities are harsh and dangerous places.

Second, rural health practitioners tended to rely on their experiential understandings of rural culture, which is discussed in chapter 6. Their patterns of language use constructed rural communities as healthy, thriving and cohesive. During the rural placement several rural health practitioners incorporated teaching and learning activities that were designed to immerse students into rural life. At times these activities sustained the meanings that had already been created in the hidden curriculum.

Third, the undergraduate nursing, medical and pharmacy students used the rural placement as an opportunity to professionally develop as generalist health professionals. They constructed their personal and professional identities in ways they believed were fundamentally different to rural people. The way students construct their professional identities has consequences for rural health education achieving its aim as a rural health workforce supply strategy.

The key argument developed in this study is the rural placement is a pivotal experience defining personal and professional socialisation and identity for undergraduate students. There were several inevitable challenges to

students' personal and professional identity that flow from the rural placement experience. Most notable is the reality that real world professional practice is so busy that holistic and patient centred care is an ideal difficult to follow in practice. For the students in this study, this reality was multiplied by undertaking their experiential learning in a new and novel rural environment.

It was within the 'different' clinical and non-clinical rural context that students had to find some resolution to ambiguous rural 'idyll' and 'ordeal' messages in a compressed time frame. For the students such resolution was difficult to achieve because rural health education, as a pedagogical space, was a poorly integrated and contested amalgam of different bodies of knowledge and power struggles. The result being, that in order to survive the students made choices about who they were and were not. Although there were many possibilities for achieving this, the students tended to 'other' the rural context. Perhaps this 'othering' occurred because it is supported by the whole historical set-up of rural health as a field. Notions of rural difference and disadvantage, and rural ordeal and idyll are sustained in many of the language practices of political lobbying, political documents, research, professional practice and education.

These arguments will now be situated within the broader research context.

## THE RESEARCH CONTEXT

This section briefly describes the national context in which rural health education has been historically conceived and researched as a rural health workforce strategy. It examines how the relationships between various stakeholders bring their own beliefs and values to shape the form and function of rural health education. In turn, these underlying beliefs and values condition the socialisation and identity-making possibilities for undergraduate nursing, medical and pharmacy students, who are engaging with rural health education. Professional socialisation and identity formation are important theoretical considerations for rural health education. To date, however, they have received little attention within the field of rural health. Instead, the prevailing research interest within the field of rural health education has been seeking to measure student's claims of rural intentionality (Callahan, 1962; Courtney et al., 2002; Critchley et al., 2006; Easterbrook et al., 1999; Fry & Terry, 1995; Gum, 2007; Hutten-Czapski & Thurber, 2002; Jones et al., 2000; Larson et al., 2004; Leeper et al., 2001; Lynch & Willis, 2000; Martyr et al., 1999; Peach & Barnett, 2000; Peach & Bath, 2000; Rhyne et al., 2006; Talbot & Ward, 2000; Wilkinson et al., 2004; Woloshuk & Tarrant, 2002; Woloshuk & Tarrant, 2004; Wood, 1998; Wright et al., 2006).

The preoccupation with measuring students' intention to work rurally with little attention given to measuring alternative outcomes of rural health education may be a consequence of the prevailing research methods used within the field. Most rural health education research tends to privilege classical

experimental models, and their associated quantitative paradigms. These research perspectives may have worked to prevent deeper theoretical questioning of how relationships might influence the educational content, processes, and outcomes of rural health education. By unmooring rural health education from its 'dock' in the positivistic paradigm and tying it up with notions of relationships and language use, a new picture of rural health education research emerges. In this section, social constructionist and critical perspectives are put forward as new possibilities for knowledge production.

The need for a more holistic way of examining rural health education is apparent when the complex forces influencing rural health are considered. Contemporary rural communities are being influenced by a maelstrom of changes and processes in Australia. These include changes in demographic patterns, levels of economic and social infrastructure, advancing communications and information technology and ever changing social and cultural values (Panelli, 2001). These are impacting unequally on various Australian groups in terms of the provision of transport, social, health and educational services (Moriarty et al., 2003). The effects of this inequality are particularly reflected in the health and wellbeing patterns of rural populations. Research is consistently finding that rural populations have a poorer status than people who live in other areas of Australia (Adam, 1991; Australian Institute of Health and Welfare, 1998; Australian Institute of Health and Welfare, 2001) .



One of the key determinants of the health and welfare of any population is the access to, and accessibility of, various health and social services (Humphreys, 2007). In rural Australia, a range of structural and social barriers are impeding people's access to, and the accessibility of, health and social services (Humphreys, 2007). Sparse populations, small towns and large distances are impeding the effectiveness, responsiveness and accessibility of health services to rural Australians. In situations of medical need, rural Australians are often required to travel long distances to access health care services, which is expensive. This travel can also exacerbate health problems and delay treatment. These problems have been worsened by difficulties rural Australia is experiencing recruiting and retaining health professionals.

In rural and remote areas, the existing rural health workforce is already experiencing difficulties in appropriately servicing their populations (Department of Treasury and Finance, 2004). It is a situation that is worsened by the shortage of health professionals across all disciplines, which are particularly critical in rural areas (Brooks et al., 2003; Jackson & Daly, 2004; Laurence et al., 2002; Wearne & Wakeman, 2004). Of the total health workforce, only 23% of medical specialists, 27% of general practitioners, and 34% of nurses work outside urban areas (Australian Institute of Health and Welfare, 2001). Reporting the workforce distribution of pharmacists is constrained by the way these patterns are included with other professions such as dentistry. Nevertheless the shortage of pharmacists in rural areas is becoming well documented (Health Care

Intelligence, 2003; Thornberry & Emerson, 2003).

Responding to the increasing workforce shortages across all health professions is one of the most pressing challenges facing the rural health system today. The rural health workforce shortages are expected to worsen over the next decade (Productivity Commission, 2005a). These shortages will impact on various minority groups who live in rural areas. Most significantly, the workforce shortages will negatively impact on the Indigenous population which already has the poorest health status in Australia (Anderson & Thomson, 2002; Eades, 2000; Hays, 2002b; Murray & Wronski, 2006; Swain & Taylor, 2006). It is anticipated that rural communities will place a significant degree of strain on the rural health workforce, which may lead to high stress levels and greater attrition. The notion that existing health professionals may leave rural areas is of particular concern, because research shows that nursing, medical and pharmacy graduates are tending to remain in metropolitan areas (Humphreys et al., 2002b). The current workforce shortages already compromise the capacity of other health and workforce strategies to address current and future health system challenges. It is a situation that is expected to worsen across all health disciplines.

Nowadays various groups and organisations are heavily investing in initiatives and programs to address these health and social problems related to rurality. At the national political level this is evident through the Australian Commonwealth government's ongoing commitment to rural health through renewed funding to support the Rural Health Strategy. The Rural

Health Strategy (Australian Health Minister's Conference, 1994) is an important initiative for improving the health and wellbeing of people living in rural and remote Australia, through funding to support a number of different programs (Australian Health Minister's Conference, 1994; Australian Health Ministers' Conference, 1996; Humphreys & Murray, 1994). It is an iterative strategy that is reviewed and updated every few years (Australian Health Ministers' Conference, 1994; Australian Health Ministers' Conference, 1996; Australian Health Ministers' Conference, 1999; Australian Health Ministers' Conference, 2003). Establishing and maintaining a stronger rural health workforce is one of the five national rural health policy priority areas that was first identified in 1996, and then reaffirmed in 2001 and 2003. Rural health education is one way of responding to these workforce shortages.

There are specific Commonwealth initiatives in place to advance rural health education in undergraduate health science programs in Australia. A national network of Rural Clinical Schools and University Departments of Rural Health have been established in most Australian states. These schools are mandated to provide undergraduate students with rural learning experiences and the departments are working towards strengthening the rural health workforce (Commonwealth Department of Health & Aging, 2005). In medicine, the Rural Undergraduate Support and Coordination (RUSC) program targets the recruitment of medical students from rural areas and seeks to increase the rural content in medical curriculum. In pharmacy, a Rural Pharmacy Workforce

Program now administers the Rural and Remote Placement (Internship) Allowance Scheme (Humphreys et al., 2000; Thornberry & Emerson, 2003). It is a Commonwealth funded program that provides financial incentives to schools of pharmacy to provide all pharmacy students with experiential placements in rural areas. Similar levels of Commonwealth funded rural workforce policy or incentive schemes are not yet available to Schools of Nursing. A major expectation of such initiatives is improved rural medical workforce recruitment and retention (Commonwealth Department of Health & Aging, 2005).

Rural health education is predominately understood as a rural workforce strategy<sup>5</sup>. Its origins are rooted in a historical period in which the field of rural health was becoming established. The 1980s-1990s was a period characterised by raising awareness about the rural condition, attracting resources to the field and establishing infrastructure to facilitate the education of undergraduate health science students in rural areas. These strategies were primarily driven by a concern for attracting students to live and work in a rural area. The concern for responding to these rural health workforce shortages has continued to gain momentum. For these reasons rural health education can be understood as a rural workforce recruitment strategy. It is a goal that is well reflected by an

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<sup>5</sup> At the same time it is important to note the workforce agenda is only part of the broader mission of rural health education. The literature review will show that many schools of nursing, medicine and pharmacy are concerned with ensuring students who do not choose to work in a rural area should have some understanding of rural practice. It is expected these contextual understandings will better equip students for engaging more positively in the future with colleagues and clients from rural areas. Furthermore, there is also some acceptance that not all students who undertake a rural placement will be willing to take up rural practice as a long term career choice. Nevertheless if higher numbers of graduates were willing to work rurally for even short term rotations then the challenges associated with rural health service provision may be somewhat alleviated.

amassing literature describing and measuring rural health education as a rural health workforce supply strategy (Curran et al., 2004; Dunbabin & Levitt, 2003; Eley et al., 2007). Nevertheless, some commentators (Lawson et al., 2000, p 1) have described rural health education as "... grand experiment in action". This is due in part to the limited evidence base upon which claims of a causal link between rural health education and students intention to work rurally rest.

There are calls for researchers to develop an evidence base to support the claim that a positive undergraduate curriculum with a rural focus is conducive to an increased interest in a rural health career (Ranmuthugala et al., 2007) . Such curricula often seeks to increase students awareness of rural health issues through various rural health education teaching and learning practices (Lawson et al., 1998). The cornerstone of rural health education is the rural placement, which is "... a period of experience (usually including clinical training experience) provided to a health undergraduate in one or more health settings in a rural area" (National Rural Health Alliance, 2004, p 3).

As a rural workforce supply strategy, rural placements are underpinned by the concept of 'rural exposure'. Until recently, rural exposure has been a largely undefined concept. In 2007, Ranmuthugala et al., fused the concept of rural exposure with that of rural curriculum and defined it as "... a complex and quite varied content and delivery ... primarily intended to provide awareness of rural medical practice and rural communities [which can also... provide greater opportunities for immersion in rural lifestyle and culture" (p. 286). In

short, from rural exposure it appears that educationalists expect students to acquire the knowledge, skills and attitude—the culture—requisite of professional practice and life in the rural setting. What this suggests is that rural health education does not occur in a vacuum: it is situated within a complex network of economic and social (including political and cultural) relations.

Rural health education has been conceived within the emerging discipline of rural health. In practice, however, it exists in relation to a number of discernible schools of thought and overlapping groups—including academics, bureaucrats, health professionals, undergraduate health science students, and rural people—in different social and professional contexts. Together these groups make up the field of knowledge production in the day-to-day teaching and learning practices involved in rural health education. They each act to shape the educational content, processes, and outcomes of rural health education. That is, each of them acts on their own sets of beliefs to create the meaning and identity-forming experiences of undergraduate nursing, pharmacy and medical school learning for students. These ideological drivers are often hidden aspects of rural health education that are rarely discussed. Ideology is defined as “... the value of belief systems which [are] accepted as fact or by some group” (Lotz, 1998). This can be understood as “an exercise of power through the manufacture of consent to or at least acquiescence towards’ the uncritical use of language” (Fairclough, 1984, p 4). A new strand of research in the field offers new possibilities for developing a perspective for making these ideological

dimensions of rural health education more visible.

Paul Worley's writings about community-based medical education (CBME) convincingly argues that 'relationships do matter' (Worley, 2002b). Worley (2002) presents a model of four relationships, the four Rs, in which the medical student must be immersed to facilitate high quality learning. These four Rs are the relationships between (1) clinicians and patients, (2) health service and university research, (3) government and community, and (4) personal principles and professional expectations. Through this model of clinical, social, institutional and interpersonal relationships Worley (2002) offers a valid framework for articulating the important principles in CBME. A fundamental question to emerge from this model<sup>6</sup> is: how do each of these groups, understood as having their own ideologically-based agency, whether direct or indirect, shape the educational content, processes, and outcomes of rural health education?

The way people interact with their environment is a topical issue that suggests rural health education might be a field of study that requires a new framework to understand these relationships. Contemporary understandings of research practice emphasise that a new mode of knowledge production is in operation. In particular, there are three new concerns that can be extrapolated from Worleys (2002a; 2002b) work on relationships that correspond to powerful contemporary research trends discussed by Michael Gibbons (1994).

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<sup>6</sup> See page [1653](#) for an extended discussion and diagrammatic representation of the Integrity Model developed by Paul Worley.

First, Worley's (2002a; 2002b) focus on relationships in rural health education shows a number of organisations and communities in rural health are involved in research, policy, education and practice. According to Gibbons (1994) there are multiple sites of research and knowledge production that may be internal or external to higher education. Rural health education research typically targets nursing, medical and pharmacy students, studying in the higher education context, as data sources in the quest to measure their intention to work rurally. The writings of Worley and Gibbons suggest that other groups, including academics and rural health practitioners, and other contexts, such as the practice setting, offer new possibilities for knowledge production.

Second, Worley's (2002) work on the Four Rs also shows there are many different groups of people—from patients to students to health professionals to academics to researchers to government—from a range of different disciplines involved in rural health. There is a growing trend for transdisciplinary and transinstitutional research (Gibbons, 1994). At present, rural health education tends to be situated within the medical discipline. Rural health is a multidisciplinary and cross sectoral concern. Rural health education therefore requires greater insight from disciplines other than medicine.

Third, rural health is characterised by a cross disciplinary, multi-institutional component of the health system that must deal with the challenges associated with vast geographical distances. It is a field that relies heavily on communication and collaboration. There are new forms of



communication that accelerate and widen access to data and research findings (Gibbons, 1994). What these trends in rural health education and contemporary research suggest is knowledge within and about rural health education emerges from educationalists and researchers in co-operation with other knowledge producers and institutions outside the university. Although rural health education is heavily reliant on the concept of rural exposure, the voice of lay people living in rural communities is difficult to locate within the field of rural health education.

Health science education academics, undergraduate students, rural health professionals and rural community members are also under-represented voices in the rural health education literature. Making their voices more audible offers the field of rural health education new possibilities for research and education. The location of rural health education in undergraduate nursing, medical and pharmacy programs at the participating university and in rural community settings are the data sources examined within this thesis. From these sources the analysis describes and tests substantive theory around the nature and outcomes of rural health education. The analysis uses techniques and methods of Norman Fairclough's (1989, 2001; 1991; 1995a; 2001; 2003; 1997) critical discourse analysis. There are two historical reasons for doing this.

Firstly, rural health education is only just becoming established as a field within itself. The past decade has been characterised by practices for enabling teaching and learning about rural health in undergraduate health

science programs. More recently, it appears that attention is shifting from what structure and infrastructure is required to establish rural health education, toward a concern with what rural health education might actually be. It seems that rural health education researchers are beginning to transfer attention from material practices, such as standalone rural placements, to developing conceptual models of curriculum content (c.f Bourke et al., 2004). Rigorous, theoretically informed understandings of the nature, process and immediate outcomes of rural health education are urgently required to assist educationalists with these developments.

Secondly, the past decade has seen some major changes in the broader field of knowledge production, particularly within the social sciences and humanities but also within sciences and technology. The historical changes that are occurring within the field of rural health education, and the also the broader field of knowledge studies, suggest it is time to raise new questions for rural health education research. For instance, what is the place of rural health education research in this new period of knowledge production? There is always the option of situating rural health education research within a positivistic paradigm and using the classic experimental methodologies and methods that have historically prevailed within the field. Alternatively, there is the option of forging a new research direction for rural health education by situating it within a new episteme and using contemporary research methodologies and methods. Rural health educationalists and researchers are making calls for the latter (Bell

et al., 2005; Black et al., 2000; Margolis, 2005; Snadden, 2006; Worley et al., 2004b).

While a great deal of rural health education research has been guided by a positivistic paradigm there is a place for a different more qualitative approach. Placing greater emphasis on the importance of relationships between various elements and people in rural health education is an alternative way of thinking about knowledge production (Worley, 2002a; Worley, 2002b). What is needed in rural health education is an alternative conception of knowledge and related forms of cultural practice. Social constructionism is a growing movement in the human sciences (Berger & Luckman, 1966; Coulter, 1979; Coulter, 1983; Gale, 2001; Gergen, 1985; Gergen, 1991; Gergen, 1994; Gergen, 1999) that provides a framework to understand these relationships. The social constructionist view holds that knowledge is what social groups or communities have come to believe (Berger & Luckman, 1966). This suggests that prevailing ideas in rural health are not so much reality or truth but social constructions<sup>7</sup> that have been advanced by dominant groups. Foucault (1972; 1973; 1975; 1977) shows at length that current received opinions do not carry any transparent truth. He argues that all dossiers are the organised historical practices which make possible, give meaning to and situate in a political field, these monuments of official statements (Dreyfus & Rabinow, 1983).

The idea that rural health education is a rural health workforce supply strategy can be understood as a social construction. Social constructionist

<sup>7</sup> Refer to pages ~~173~~, ~~353~~, ~~1723~~ for further discussion on social constructionism.

perspective emphasises that people's ideas are given meaning by their social context (Berger & Luckman, 1966). It is a view based on the premise that it is the social context of meanings that is fundamentally important, not their ideational content. According to McNamee & Gergen,

*"... our formulations of what is the case are guided by and limited to the systems of language in which we live. What can be said about the world—including self and others—is an outgrowth of shared conventions of discourse. Thus, for example, one cannot describe the history of a country or oneself on the basis of 'what actually happened'; rather, one has available a repertoire of story-telling devices or narrative forms and these devices are imposed on the past....In effect, what we take to be 'the real and the good' are largely textual histories" (1992, p 4).*

This suggests that individuals and groups working in the field of rural health are bound to sets of rules within their particular social contexts because they share a particular cultural vernacular. Language theorists claim that '... we can never get outside language to attain knowledge of an independent—extralinguistic—reality' (Held, 1995, p 8). This suggests that each group of people contributing to rural health education will draw on a particular language system, which has its own particular way of distorting, filtering, constructing meaning. Although social constructionism has emerged from a long and established tradition within the health sciences, it has only recently penetrated the rural health education field. Worley's (2002b) work on CBME presents promising new insights into rural health education that are missing in research, which is largely based on a positivistic paradigm. It not only provides the opportunity for researchers to identify the importance of relationships, it foregrounds the messy and complex ideological drivers in rural health education.

The humanities and social science disciplines have a long and established tradition in examining moral, political, and ethical issues that pertain to different groups of people contributing to knowledge production in contexts of education. A main mode of thought embraced by these disciplines is the need to adopt a critical stance in academic practice: to push aside common sense and refuse to accept taken for granted symbolic organisations as truth (Wexler, 1982). Without a developed critical perspective, rural health education is at risk of not probing past the obvious. This may result in seemingly benign practices reinforcing or affirming everyday culture as natural or inevitable, which may be negatively impacting on rural communities. Critical perspective is crucial for highlighting the important roles students, academics, rural health practitioners and governments can assume to recognise and disrupt oppressive practices that may exist in higher education that perpetuate the marginalisation of rural people.

## THE POLITICAL CONTEXT

In this section, the political context of rural health education will be outlined.

Rural health education is a field characterised by a strong history of political activism. Throughout the 1970s, various sectional pressure groups formed to raise the rural profile and provide a voice for rural Australia (Dade-Smith, 2004). Grassroots political activism in rural health originated from a concern with rural agricultural policy (Aitken, 1985; Dade-Smith, 2004). These concerns soon became focussed on the decline of commercial and

public services and the declining economic base for those living in rural areas (Wilkinson & Blue, 2002). People living in rural areas, who were experiencing difficulties accessing public services and feeling the effects of the economic squeeze, were becoming increasingly frustrated with this situation.

Grassroots campaigns began and rural representatives toured the states of the Commonwealth to meet with rural associations, local government councils and shires. The primary goal of these meetings was to equip those attending for "constructive electoral action against financial policies which are rapidly destroying the basis of rural independence" (Brockett, 1997). Rural political activism was informed by a concern for development and democratic governance stemming from the changing global perspectives about health. At this time health was becoming positioned as part of a country's economic and social development. Rural activists therefore formulated arguments that if a country was to develop it had to consider social and cultural aspects, as well as its economic imperatives.

People were becoming more vocal about the ways economic, cultural and demographic issues were influencing their equitable access to health services in rural areas. For instance, in 1976 Dr Bob Cooter, a rural doctor, worked with the Australian Medical Association (AMA) to survey rural practice in the Eyre Peninsula and far north of South Australia. The team found many deficiencies in the work force and in standards of practice (Kamien, 2006). Many of the study recommendations were taken up in South Australia to improve health

outcomes (Kamien, 2006). The difficulties rural communities were experiencing accessing rural health services, the shortages of rural health workforce, and the poor health status of Aboriginal people were first identified in the 1970s (Hospital & Health Services Commission, 1976). In 1977 the Australian Bureau of Statistics released a national health status report which rural activists used to highlight the existence of significant differences in health status between urban and rural populations. The notion of rural difference and disadvantage became a strong point of leverage for political lobbying.

The evidence of a rural-urban health status differential added a new dimension to arguments for better access to health services. The main factors determining demand for health care services include economic factors (income and prices), cultural factors (age, sex, education, geographic context), and incidence of illness (health status differentials) (Feldstein, 1999). The rural-urban health status differentials were evidence that cultural, social and economic determinants were negatively impacted upon the health and wellbeing of rural Australians. In recognition of these issues a myriad of health professionals working in rural Australia began to form associations to create professional forums for their voice to be heard, share information, address key issues of concern and to lobby governments on matters of policy affecting rural clients, health professionals and rural health agencies (National Association for Rural Mental Health, The Australian Council of Community Nursing Services). Many groups worked hard to attract government attention to a range of rural health

issues (Humphreys, 1997; Walpole, 1979).

The political response to reports of rural-urban health status differentials, and grassroots political lobbying from rural groups throughout the 1970s was initially slow. Nevertheless, with a continuing campaign of grassroots political activism, people eventually stimulated change. Health professionals managed to raise awareness about rural health issues. In an attempt to draw greater attention and more health resources for rural areas, health professionals from a variety of disciplines met in 1991 at a conference to discuss ways of effecting change, and persuading others to take the rural concerns seriously (Humphreys, 1997). The conference was held at Toowoomba and therefore became known as the Toowoomba Conference. It marked an important event in rural health policy because it was at this conference that many of the rural peak bodies were formed (such as the Association for Australian Rural Nurses Inc, Rural Doctors Association, National Rural Health Alliance, and The Remote and Isolated Pharmacists Association). The Toowoomba conference proceedings produced a set of recommendations advocating for policies and programs to be developed to address rural health.

Emphasising the rural plight is not only an effective way of drawing attention to rural health; it continues to be an effective political strategy for attracting resources to the field. It is therefore a highly effective form of power, or the ability to produce intended effects (Russell, 1938). Power is one of the basic dimensions of all human experience, whether at the interpersonal,



group, or societal level. The political lobbying that occurs within the field of rural health allows for two kinds of power noted by social scientists, collective power and distributive power.

Within the field of rural health collective power is evident in the way different groups have demonstrated their capacity to realise a common goal: working to improve the social conditions for rural Australia. It is an essential form of power, but it is often taken for granted, and rarely spoken about. Collective power makes the existence of distributive power possible. Distributive power is about who has power over whom and what (Wrong, 1995). In the field of rural health, distributive power is reflected in the way different groups have the power to influence government's decisions about the distribution of scarce resources. In this regard, collective power in rural health can be understood as the "... capacity of some persons to produce intended and foreseen effects on others" (Wrong, 1995, p. 2). Although these actions are often well intended, they can often have unintended and unforeseen effects on others. The difficulty for rural people is this process of communication now represents them within a model that focuses on the problems that rural communities are experiencing, rather than emphasising its assets.

At this point the Commonwealth government recognises the future is likely to place greater pressure on rural people, health professionals and services. Government reports now document that without intervention the health status of rural people is predicted to decline even further. As well, the rural

health workforce shortages are expected to worsen over the next decade (Productivity Commission, 2005b). Consequently, there has been a significant political response to the 'rural crisis' from all levels of government, and across all Australian states. In this research, notions of rural difference and disadvantage are not considered to be representative of the rural condition. Instead they are understood as discourses. Discourse is a term being used as Foucault (1970) intended, as a set of rules or constraints that make certain statements, and not others, possible in particular historical, social, and institutional contexts.

The overall aim of constructing rural populations within discourses of difference and disadvantage is to establish a framework for optimising the creation, sharing and use of knowledge and resources within society. The Australian Commonwealth government supports a wide range of health service models, rural health workforce, rural health policy formation and economic initiatives to ensure rural communities have better access to health services. Health service models and national financial structures have been reconfigured to better accommodate the health needs of rural and remote communities (Wakerman et al., 2006). For instance, multi-purpose services, the Royal Flying Doctors Service, Telehealth service, and outreach services are now well established programs for increasing people's access to health care in rural Australia (Wells, 2000). Since 2004, incentive payments have been available for General Practitioners to recuperate fees for service through the Strengthening Medicare program (Humphreys, 2007). While these initiatives are expected to

assist many isolated and socio-economically disadvantaged rural and remote families, there is a need for additional interventions and support that take into account other determinants of health.

It is well recognised that the impacts on health and wellbeing extend beyond health service access and provision to include other socioeconomic determinants (Humphreys, 2007). For example, there is an urgent need for improved transport, housing and information and communication technologies in rural areas. In response to this, the Commonwealth government has established the Rural Private Access Program to support small independent hospitals and supports community development through the Community Development Employment Program (Commonwealth of Australia, 2002). These initiatives are a significant step in addressing many of the problems in rural health. With a comprehensive national rural health policy structure now in place the government expects other professional groups and institutions to take advantage of various support programs to design and implement programs that will improve the rural health situation.

A number of rural health policies have been developed and implemented over the past decade. Policies that are specifically oriented toward rural workforce development have generally emerged from the Regional Health Strategy: More Doctors, Better Services (2000-2001) package, worth \$562 million to increase the supply of medical and allied health professional and rural health services (Humphreys, 2007). Many of the initiatives within this package

were designed to reinforce and build upon those already in existence. For example the Practice Incentives Program (PIP), the International Medical Graduates (Han & Humphreys, 2005; Hawthorne & Birrell, 2002). In 2004 the Australian Commonwealth government committed another \$62.9 million over four years from 2004-05 to the More Allied Health Services (MAHS) Program. Many of these programs centralise rural health education as the main strategy for addressing the rural workforce shortages. It is within prevailing discourses of rural difference and disadvantage that rural health education has been conceived, which is centralised in the research problem outlined in the next section.

## IDENTIFICATION OF THE RESEARCH PROBLEM

In this section the research problem is identified and condensed into one main and two secondary research problem statements.

Universities, as institutes that produce new graduate health professionals, play a crucial role in operationalising many rural health workforce policies in an attempt to alleviate the rural health workforce shortages. The concern raised in this research relates to the way rural health education has been conceived within a cultural deficit frame for understanding rurality. It is within discourses of disadvantage and difference that rural health education is seeking to increase and strengthen the rural health workforce. One such initiative in place is to increase the number of student enrolments in undergraduate medical and pharmacy programs (Rural Undergraduate Steering Committee, 1994;

Thornberry & Emerson, 2003). Another is the provision of rural health workforce policy incentives to encourage universities to provide undergraduate health science students with rural learning opportunities (Rural Undergraduate Steering Committee, 1994).

Rural health education is being advanced by educationalists, researchers and bureaucrats as one of the main ways of encouraging undergraduate nursing, pharmacy and medical students to consider and positively evaluate rural practice as a rewarding career option. Despite these expectations, there has been little research interrogating how students come to understand what it is like to live and work in a rural community that may be in crisis and extreme need. There are now calls for researchers to identify the particular aspects of rural exposure and rural health education that result in a favourable attitude towards rural practice. It is expected that a favourable attitude will influence students' decisions to work rurally as health professionals (Ranmuthugala et al., 2007).

Attracting students to rural practice is contingent on a multileveled strategy that incorporates best practice models of rural health education, which are theoretically informed and based on evidence. Rural health, and therefore rural health education, is a relatively new field. The difficulty for curriculum planners is there is a limited number of research-based information about the constructs and concepts that may be valuable for rural health curricula. Conceptual frameworks that have been recently developed emphasise rural problems and tend to draw upon discourses of difference and

disadvantage (c.f Bourke et al, 2004). As well, the literature does not clearly identify the specifics of what a rural health professional might be, what they need to know and how they can best learn. Despite these gaps in knowledge, the value of exposing students to rural professional life and providing access to a wide variety of learning experiences in the rural setting has been well recognised (Hays & SenGupta, 2003; Hays et al., 2005; Ranmuthugala et al., 2007; Snadden, 2006).

Through learning experiences in the rural context students are expected to acquire a sense of what it means to be a rural health professional. In order to positively evaluate rural practice as a viable and rewarding career option, students must be able to understand, assess, and affirm the beliefs, processes and nature of rural practice. Understanding implies students have come to understand the structure and processes that are distinctive of rural professional practice. Assessing implies students will judge the worth or value of various dimensions of rural practice based on their own criteria. Affirming implies that students will choose to adopt or not adopt the beliefs, attributes and norms valued in rural practice. These values, habits and attitudes create the socialising conditions for students to develop in a professional manner (Kalmus, 2006) while also learning about rural communities. They can also be critical for shaping students' personal and professional identity (Niemi, 1997). As students are confronted with the need to make choices about those values, habits and attitudes to adopt or not adopt, their identity plays a crucial role in their

decisions about assessing rural practice as a positive and viable career option.

The way students are socialised in rural health education depends upon the way rural curriculum is understood and used in health science education. Curriculum design and delivery in these programs depends on the beliefs, values and goals individual schools are trying to achieve in their undergraduate programs. Decisions about what is and what is not, considered appropriate for inclusion in these programs make rural health education susceptible to institutional politics. “What goes on in educational institutions; neither what is taught, nor who studies what, are neutral issues” (Deem, 1996, p 51). The place of rural health education in the academic program, learning objectives, teaching and learning procedures are not only processes of exclusion and inclusion, but also processes of power. It is a form of power that differs from the top down or bottom up accounts of power discussed earlier in this chapter<sup>8</sup>. It is a form of governance in which individuals elect to modify their behaviour in order to fit with group norms. In other words, governing is the process through which contemporary practices of governing (Dillon & Valentine, 2002) work to regulate, ‘the conduct of conduct’ (Foucault, 1991).

While academics and health professionals might think their actions are neutral they are shaped by their internalisation of the social order of their academic or professional institutions. This is a form of governmentality, which Foucault (1979) explains is the internalisation of order that makes possible

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<sup>8</sup> The concepts of collective (page 413) and distributive (page 413) power have been discussed elsewhere in this chapter.

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modern governance. Knowledge, according to Foucault (1980) is always a form of power, and knowledge can also be gained from power. In his view, knowledge is forever connected to power, hence his tendency to represent them as: power/knowledge. The knowledge held by academics and health professionals is therefore always a form of power:

*Knowledge linked to power, not only assumes the authority of 'the truth' but has the power to make itself true. All knowledge, once applied in the real world, has effects, and in that sense at least, 'becomes true.' Knowledge, once used to regulate the conduct of others, entails constraint, regulation and the disciplining of practice. Thus, 'There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations (Foucault, 1975, p 27).*

From Foucault's writings, power can be seen to exist everywhere and come from everywhere. It acts as a type of relation between people, and can work as a strategy that has the potential to subtly shape another's behaviour by producing certain 'rituals of truth' (Foucault, 1979, p 194). Thus, rather than attributing the effects of power to the Commonwealth government, this research focuses on procedures and processes in rural health education that may produce truth as a power effect.

While the focus on government, power and discourse has a major focus in the social sciences and humanity fields (Goodwin, 1998, p 12; Little, 2001), it does not have the same emphasis in rural health education. This research proposes to reorient the current focus on the means of power to consider its effects in rural health education. Rather than drawing upon discourses of rural difference and disadvantage that are used to influence the inequitable distribution of resources



in Australian society (means of power) it might be beneficial to examine ways power emerges from rural health education (effects of power). Burbules (1994) argues that a focus on the means of power serves to segment it into various forms that leads one to regard these as natural divisions, rather than as categories that are socially constructed. Efforts to improve social conditions for rural communities through arguments of disadvantage and difference may have overshadowed other ways of knowing them. The effects of power relate to the way knowledge (discourse) is shaped in rural health education, which in turn shapes the possibilities for constructing meanings about rural communities.

There are strong indications that it is time for educationalists and researchers to consider what might be conveyed to students through the power of language in the everyday practice of rural health education. The work of Dupuis & Vandergeest (1996) is particularly useful for illustrating why this is an important consideration. In the book, *Creating the Countryside: The Politics of Rural and Environmental Discourse*, a range of rural area case studies are assembled in a way that reflects the way outsider's words have impacted on peoples' lives. Institutions with power have constructed cultural frameworks for understanding rural areas (DuPuis & Vandergeest, 1996). These frameworks are not only used to define problems, but also used to justify particular policies. While these policies are often attempts at improving the social conditions for rural communities, they also work to establish particular discourses about rural populations. Once this occurs, it is difficult to perceive alternative ways of

understanding. Moreover, these discourses are often imposed from the outside and can often differ from the actual “histories and lives of people in rural areas” (DuPuis & Vandergeest, 1996, p 3). When these insights are applied to the field of rural health, concerns about the governability of rural populations and the processes of governance are foregrounded.

Historically, the frameworks for understanding rural people, places and practice have been organised within discourses of difference and disadvantage<sup>9</sup>. Rural communities have had little say in this process. If we are to be guided by DuPuis & Vandergeest’s (1996) claims about the relationship and outcome of language use and power, questions need to be asked about the role rural health education might play in the reproduction of these established ways of understanding rural health and practice.

The issues raised above can be condensed into one main and two secondary research problems that are addressed in the course of this study. The main research problem is formulated as follows:

- the socialising effects of rural health education on students' identity formation are currently unknown and as such cannot be subjected to rigorous critique through which to advance theoretical understandings of the field.

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<sup>9</sup> The rural activism and strong political lobbying discussed on page 373 of this chapter is an example of how language has been used within rural health to construct rural places as different and disadvantaged.

Based on the main research problem, two secondary research problems are defined as follows:

- the ways different groups use different patterns of language use construct, and convey their interpretations of rural people, places and practice in rural health education, are not known and understood,
- the different ways in which different groups—from governments to researchers to educators to health professionals to students—act to shape the educational content, processes, and outcomes of rural health education are not known and understood.

These issues are not yet reflected in the rural health education literature and therefore invite investigation. The concern in this research is with how the language or ‘truths’ associated with ‘rural disadvantage’ and ‘rural deficit’ are taken up in medical, nursing and pharmacy schools and how these shape the ways academics, rural health practitioners and students think and act. In their teaching and learning practices, these groups and individuals draw on knowledge constituted in the disciplinary fields of rural health and medicine to construct rural people, places and practice as being in need of intervention and support. Classroom and rural community spaces therefore provide resources to conduct “a certain number of operations on ... bodies and souls, thoughts, conduct, and way of being” (Foucault 1997, p.225) in order to attract students to rural practice as a viable career option.

Following Foucault (2001), this research 'problematise'<sup>10</sup> the way rural health education has become known as a rural health workforce supply strategy, and examine the effects of its associated discourses of rural disadvantage and deficit on how academics, practitioners and students come to understand rural people, places and practice. The role of rural health education as a process of professional socialisation and identity formation is largely under-theorised in this field. The research to be reported in this thesis is therefore a response to these gaps and the acknowledged need for further research to be undertaken in this area (Worley, 2002a; Worley, 2002b).

## RESEARCH PURPOSE

The purpose of this study was to describe and interpret how academics, health professionals and undergraduate nursing, pharmacy and medical students produced and made sense of different social semiotic meanings in rural health education and considered how students' identities were shaped by these influences. In addition, a new research framework based on theories of power, space, discourse, socialisation and identity had to be developed. The study presented in this thesis offers novel insights into its operational detail of the

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<sup>10</sup> Foucault rejects the notion of truth and therefore encourages researchers to think critically about notions that are taken-for-granted in their practices. Rather than simply operationalise these accepted concepts and constructs in their studies, Foucault (1980) calls for researchers to 'problematise' them and consider other possibilities. For example, this study does not simply operationalise rural health education as a rural health workforce strategy but instead considers it as a process of socialisation and identity formation. Calls for 'problematism' are also reflected in the work of Bruce who urges researchers to swim against the tide, to speak outside of the circle, to revive the validity of ephemeral soft 'stuff' by speaking the 'unspeakable'. Similarly, Lather suggests research should problematise the local, starting with the every-day particularities of lived experience, because "[t]he social happens", on the basis of an existing network of "concepts, ideologies, theories, ideas and so forth"

practice of rural health education in undergraduate nursing, pharmacy and medical programs by accomplishing the following aims.

First, it examined the ways various groups construct rural health education in different institutional and cultural spaces.

Second, it described and interpreted the cultural representations of rural communities that are being produced and reproduced within the day-to-day practice of rural health education.

Third, it considered how students' identities are enmeshed in these spatial relations of power and knowledge.

Fourth, it examined how these construction processes might be conceptualised and analysed.

Fifth, it sought to explain how these relations between meanings and practices in the pedagogical space have implication for the realisation of the implicit goals of the rural health workforce supply agenda.

In order to achieve these purposes an additional aim of the study was to develop and test a conceptual and analytical framework which could be critically examined. This framework is presented in chapter 3.

## RESEARCH QUESTIONS

Four research questions were used to guide this study of rural health education as an adequate rural health workforce supply strategy.

How is rural health education constructed within the rural health literature?

How do academic and health professionals understand rural health education as it relates to the broader core curricula of an undergraduate nursing, medical and pharmacy program?

How does the day-to-day teaching and learning practice of rural health education construct how rural communities can be known and understood in language?

How does rural health education shape undergraduate nursing, pharmacy and medical students' personal and professional identity?

Is rural health education meeting its intended aim as a workforce strategy in terms of instilling in students an interest in a rural career?

To address these questions, the way in which rural health education is conceptualised as a pedagogical space to which different groups bring their beliefs that shape meanings about rural people must be understood. These sets of meanings and values condition the identity-making possibilities for students who are engaging in rural health education activities.

## THE PEDAGOGICAL SPACE FOR RURAL HEALTH EDUCATION

Within this research the conceptual framework for understanding rural health education is that it is a contested pedagogical space in which the

socialising process occurs in different socio-cultural settings and involves different groups.

Rural health education is a multidimensional set of educational activities that incorporate aspects of teaching and learning that cross different institutional, professional and social spaces. Within each of these spaces academics, health professionals, students and rural community members will have their own sets of social, cultural and professional beliefs. Each of these groups will organise their values and beliefs in discernible ways. The term 'boundary' is a useful metaphor for the limits of particular branches of knowledge, behaviours and practices for each of these socio-cultural groups. These insights about knowledge, behaviour and practices are informed by the long established tradition of cultural anthropology, social sciences and humanities (Geertz, 1973). Discourses that are in circulation in each of these spaces will define the boundaries demarcating acceptable knowledge and practice for these groups in these spaces. The thoughts and actions of individuals within these different institutional, professional and social spaces are shaped by processes of governance and governing<sup>11</sup>.

When the boundaries of these groups cross, the interstices create a new space for rural health education. This is diagrammatically represented by Figure 1. Each of these different groups—from educators, health professionals, rural community members and students—will bring their own sets of social, cultural

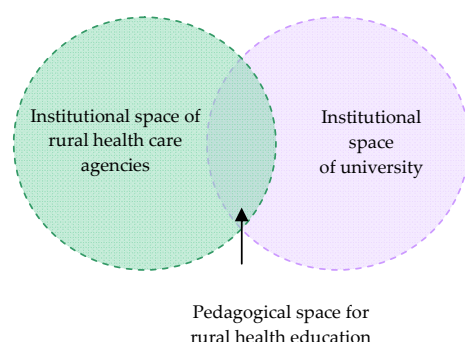
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<sup>11</sup> The concept of governance was defined on page 143 and discussed in more detail on page 473 of this chapter.

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and professional beliefs to define the boundary of the pedagogical space. This can also be known as boundary work, which is defined as “...the set of differentiating activities that attribute selected characteristics to particular branches of knowledge on the basis of differing methods, values, stocks of knowledge, and styles of organisation” (Klein, 1996). Boundary work often involves material practices that individuals and groups engage in to protect symbolic knowledge within a particular disciplinary space.



**Figure 1111, The pedagogical space for rural health emerging from the interstices of institutional boundaries**

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The pedagogical space for rural health education is a contested site. The knowledge and practices from each group moves to and from the pedagogical space for rural health education. While the knowledge and practices within rural health education can appear relatively protected, its demarcation boundaries are vulnerable and subject to being contested. Decisions about what knowledge and practices are included or excluded within rural health education or what attains privilege and legitimacy, for the most part fall upon groups who have the capacity to actively transport knowledge in or keep it out of the



boundary. If discipline boundaries do happen to change so too can the core knowledge and practice of rural health education. These dynamics suggest that professions, disciplines and social groups are in a constant state of crisis as they struggle to maintain their identity through keeping core knowledge and practice constant. The corollary of this is rural health education is also in a constant state of crisis. Individual members of these different groups may act as agents of socialisation for the students who play an important role in affecting their thoughts, behaviours and identity-making possibilities.

Students are not passive objects of this socialisation process (Parsons, 1959). Instead, processes of social interaction in the pedagogical space for rural health education involve students in a dialectical process. A dialectical account of socialisation is a "... complex, interactive, negotiated, provisional process ... that stresses the importance for man [sic] as a creative force, as a searcher for solutions and possessing a considerable potential to shape the society in which he lives" (Zeichner, 1980, p 22). This perspective of professional socialisation emphasises the importance of social interaction between students and their spatial environment, the mutual influence and their continual effects (Cheng & Pang, 1997). From the dialectical perspective the individual is recognised as playing an active role in the socialising process when an interaction of different components is considered (Cheng & Pang, 1997).

The next section proposes an alternative way of theoretically examining rural health education as a process of professional socialisation. It is a

conceptual framework that allows for some thick description and analysis of rural health education in action. It also allows students' personal and professional identity formation to be analysed as a new measureable outcome of rural health education.

## CONCEPTUALISING RURAL HEALTH EDUCATION AS A PROCESS OF PROFESSIONAL SOCIALISATION

The links that have been drawn between everyday practices and meanings, and power and discourse, make it possible to engage research with theory in ways that have not yet been considered within the field of rural health education. In this section rural health education is conceptualised as contested pedagogical space in which students undergo a process of professional socialisation and identity formation. It is a metaphorical space in which various individuals and groups—from bureaucrats, academics and health professionals—as socialising agents produce and reproduce their ideological beliefs. These values, habits and attitudes create the symbolic conditions for students to develop in a professional manner and learn about rural populations. They can also be critical for shaping students' personal and professional identity. As students are confronted with the need to make choices about those values, habits and attitudes to adopt or not adopt, their identity plays a crucial role in their decisions about assessing rural practice as a positive and viable career option.

In this research the process by which students learn about rural people,

places, health and practice is known as professional socialisation. The term socialisation refers to a range of processes related to the development of individuals within social systems. Weidman, Twale & Stein (2001, p 4) define socialisation in a broad sense as "...the process by which persons acquire the knowledge, skills and disposition that makes them more or less effective members of society". Professional socialisation is defined as "... a subconscious process whereby individuals internalise behavioral norms and standards and form a sense of self and commitment to a professional field (Weidman, Twale & Stein, 2001, p 6). It is a process that can lead to the internalisation of professional culture and development of a professional identity (see below for extended treatment). Thus rural culture, through 'rural exposure' (Ranmuthugala et al., 2007) can be learned through social interaction with professionals and educators during a student's education. Research of the professional socialisation process within the field of rural health education has not yet been attempted or explored in Australia, or even internationally. Salient for the understanding of the dynamics of the professional socialisation process is recognition that it has fundamental parts and is developmental in nature. There are six themes that emerge from the professional socialisation literature. These include,

- sociological definitions of professions and disciplines;
- disciplines for which students are being prepared;
- education is a form of secondary socialisation;

- personal and professional identity is an outcome of socialisation;
- professional socialisation and identity is shaped by social context and social interaction, and
- socialisation and identity formation is context specific.

There are numerous sociological definitions of professions and disciplines. In this study, a profession is defined as "... an occupation that regulates itself through systematic, required training; that has a base in technical, specialised knowledge; and that has service rather than profit orientation enshrined in its code of ethics" (Starr, 1982, p 72). According to Friedson (1970), the word profession relates to meanings associated with the notion of 'occupation' and 'membership'. Members of a particular professional occupation have an avowal from the government or other registering authority to legitimately engage in practice. All of the students in this research were enrolled in formal processes of study to become members of a particular health profession.

The aspect of professional life for which students are preparing can also be understood as the discipline or field of specialisation that students are working toward. In addition to becoming health professionals the students in this study are participating in rural health education. These educational activities are designed to expose students to a particular discipline, which is becoming known as rural medicine. A discipline is defined as being "... characterised by a

unique perspective, a distinct way of viewing all phenomena, which ultimately defines the limits and nature of its inquiry” (Donaldson & Crowley, 2002, p 10). Roger Strasser (1995) has been engaged in a long standing effort to establish rural medicine as a distinct discipline based on four criteria: an academic body, a training program, a unique literature, and recognition from outside. Several researchers have commented that all but the last criteria have been fulfilled (Dade-Smith & Hays, 2004). Both professions and disciplines can be understood as social constructs that have their own language, belief system, and cultural rules. These are passed onto students through social interaction.

The knowledge and understandings that students bring to the situation of education play an important role in the socialising process. Helen Tolhurst (2006; 2006; 2003; 2004) and her colleagues’ work is particularly useful in this area. This qualitative strand of research explores the attitudes of Australian medical students to the balance between work, family and other aspects of lifestyle, within a broader exploration of the issues that they regard as important to their decisions about future career. It is a body of work that recognises the way students bring to their own sets of expectations and habits, based on their social experiences, to rural health education.

Education works as a process of secondary socialisation in which the transmission of a specialised body of knowledge occurs. Rural health education extends the traditional institutional boundaries of the university. Much of students’ learning emerges from the university setting, but also the

professional setting of health care practice and the social setting of the rural community. In this research, education is a term that refers to the traditional expert domain of academia as well as the spheres of lay and 'professional thought that enlarges the professional knowledge base' (Jackson, 1970).

The social values held by a particular profession or disciplines are connected to the definition of group member's professional identity. Identity is understood as a multidimensional set of categories that are culturally and historically produced in relation to the available cultural texts (Hall, 1996). Identity is plural, not singular. It is never a stable or fixed category because it is always in formation (Gee, 2000-2001). Nevertheless, professional identity is defined as the relatively stable and enduring constellation of attributes, beliefs, values, motives, and experiences in terms of which people define themselves in a professional role (Schein, 1978). The notion of professional identity has not even entered the debate at a conceptual level within the field of rural health education.

Lastly, the socialisation process takes place within particular sociocultural settings whereupon knowledge, beliefs and values are transmitted through social interaction. It has been of interest to professional socialisation authors to look at the relationship between individual's professional development and identity formation (Schieen 1978). Several writers describe the process whereby students learn the attitudes, values, knowledge, beliefs and skills occurring through social interaction. The exchange of norms and values shared by a professional group can lead to individuals taking up the professional role. This is a process

whereby particular values, attitudes and beliefs are internalised, which leads to the subjective self-conceptualisation associated with that social context (Hall, 1987; McGowen & Hart, 1990; Watts, 1987). It is, therefore, a process in which power and discourse can be understood as being spatially connected in rural health education in ways that shape students sense of self.

The themes in the professional socialisation literature were used as the theoretical framework for the study. Theoretically the study will be approached as follows.

The major parts of the professional socialisation process consist of anticipatory, formal, informal and personal socialisation. These reflect different levels of understanding and commitment to the professional roles for which students are being prepared. Each part involves a process of engagement through core elements of professional socialisation that lead to increasingly more advanced knowledge acquisition and involvement in the culture of the academic program. The phases of role acquisition, described by Thornton & Nardi (1975) provide a useful organising framework for the analysis of rural health education as a process of professional socialisation. As such, the anticipatory, formal, informal, professional and personal socialisation dimensions of rural health education are considered within this study.

The anticipatory socialisation process covers the preparatory and recruitment phases as students enter rural health education. This was important to this study because the reasons why students select health

professional careers can reflect the anticipatory socialisation process. The literature review (chapter 2) shows that primary socialisation agents<sup>12</sup> such as school, family, friends and geographical place are a key source of information about the anticipated role and the profession for students. Through social interaction, students learn and acquire new understandings of rural culture. These can either be integrated into student's prior belief and value systems (otherwise known as personal identity) they bring to the pedagogical space for rural health education, or they can be rejected.

The processes of interaction, integration and learning in this study will take place according to the remaining perspectives of professional socialisation, namely the formal, informal dimensions and students' professional identity formation. Contemporary accounts of professional socialisation tend to centralise the importance of social interaction and take into account the way relations of power and discourse shape the process in different contexts (chapter 3). It is the process "... by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short, the culture – current in groups of which they are, or seek to become a member" (Merton, Reader & Kendall 1957, p. 278).

The formal professional socialisation process is the phase where students are inducted into their chosen vocational field (chapter 5). All of the students in this study are engaged in a broader professional socialisation experience that

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<sup>12</sup> Refer to page 1273 for an extended discussion of the concept of primary socialisation agents.



consists of the normative context. For instance, the teaching and learning activities within the undergraduate health science programs at the university under study. Rural health education is one such set of teaching and learning activities that take place within this broader normative context.

The informal professional socialisation process is the part where students are inducted into rural practice by rural people who may or may not be involved with health care and professional practice in the rural community setting (chapter 5). It also involves those individuals and groups who may not play an active role, but have a significant influence, in students learning or experiences of rural health education. Bureaucrats, politicians and the media are examples of indirect socialising agents in rural health education.

The eventual outcome of professional socialisation is the formation of a professional identity. Professional identity has been well investigated in the health sciences (Barnes et al., 2000; Carpenter, 1995; Hind et al., 2003). For example, nursing students in their final year do not show a strong professional identity (Carpenter 1995). Conversely, final year medical students (Carpenter 1995) and health care students (Hind et al., 2003) have been found to have strong professional identities at this stage. Ideology, conveyed through social interaction, has also been found to influence the way medical students shape their professional identity (Apker & Eggly, 2004).

Professional socialisation might affect the power and achievement motives of students, which in turn may influence their career-related

decisions. Most undergraduate students are driven to succeed and do well in their studies. These behavioural attributes are driven by the need to seek particular outcomes (Lips, 2001), such as passing coursework and becoming registered as a health professional. The way the pedagogical space is defined by different groups therefore plays a significant role in shaping for rural health education because students invest in this space to empower themselves. The location of rural health education in the undergraduate nursing, medical and pharmacy programs significantly influences the power relations that shape the identities of the students as well as the ability to exercise power. Thus the location of rural health education is not just a matter of technical programmatic exercise as typically assumed. Instead, it represents a set of contested dilemmas because the social interaction between academics, rural health practitioners and students has important consequences for their ability to exercise power in ways that influences student's identity formation.

It seems that power, space and identity formation are inextricably linked in the process of professional socialisation. In order to account for these complex relationships an account of power that reasserts space into social analysis is required (Lefebvre, 1974; Soja, 1989). Contemporary social analysis emphasises that knowledge and power are not only interconnected (see, e.g., Foucault, 1980; Giddens, 1984) but also closely interlaced with space in ways that shape social practices (Friedland & Boden, 1994; Lefebvre, 1974; Soja, 1989). Space, whether a university classroom or health care agency or metaphoric pedagogical site is

political: "... space is not a scientific object removed from ideology and politics; it has always been political and strategic" (Lefebvre as cited in Soja, 1989, p. 80). Instead, it is "... fundamental in any form of communal life; space is fundamental in any exercise of power" (Foucault 1984, p. 252). In this study, the nexus between space, knowledge, power and identity is critically examined.

Power is, " ... is not 'owned' by some privileged person or group and exercised simply as an obligation or a prohibition on those 'who do not have it' (McHoul & Grace, 1993). Instead, according to Foucault,

*"... power is everywhere; not because it embraces everything but because it comes from everywhere ... Power comes from below; that is there is not binary and all-encompassing opposition between ruler and ruled at the root of power relations, and serving as a general matrix- no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body. One must suppose rather that the manifold relations of force that take shape and come into play in the machinery of production, in families, limited groups and institutions, are the basis for wide-ranging effects of cleavage that run through the social body as a whole" (Foucault, 1982).*

Although complex, it is a useful definition because it reflects the way power is not merely a physical force but an all encompassing human dynamic that is capable of determining our relationships to others. This suggests that the most forceful types of power do not arise through the efforts of one individual, group or social institution overpowering another.

The effects of power are often so taken for granted they frequently remain unexamined. This suggests that the study of power in rural health education should therefore begin with an examination of the way academics, practitioners and students participate in its day-to-day operation. Examination of

these micro-mechanisms of 'disciplinary' power is what Foucault (1980) refers to the analysis of capillary power. Foucault describes power as "capillary" (Foucault, 1980, p 96). It is never localised or centralised but instead circulates because it is, "employed and exercised through a net-like organization" (Foucault, 1980, p 98). Thus, all individuals are enmeshed in power relations that operate on them. It is because of the subtle way that power operates on people that its effects often go unnoticed. For these reasons, rural health education practices were the main subject of interest in this study and not individual's intentions.

## OVERVIEW OF STUDY APPROACH

In this section, the approach to the study is briefly outlined. An indepth discussion of the research design appears in chapter 4. The research seeks to make some sense of inherent tensions associated with how the pedagogical space for rural health education is constructed and used by rural health education researchers, academics, rural health practitioners and undergraduate nursing, pharmacy and medical students. This interest gave rise to a search for ways to examine the everyday talk in the daily operation of rural health education to deal with an analysis of power and the constitution of subjectivities. A key point of departure for the research was the assumption that in operation rural health education creates a bounded pedagogical space that could also be regarded as a social text. This social text was an important curriculum aspect of rural health education, which had dimensions that shaped not only students learning

experience but also their personal and professional identities.

By acknowledging knowledge is an effect of power in undergraduate nursing, pharmacy and medical education, it was impossible to separate the production and reproduction of rural health knowledge from the semiotic representations of knowledge in these programs. The research therefore required an approach that would describe the different professional, social and cultural contexts in which rural health education is situated and advance examination of their relationship to students' professional socialisation and identity formation. It also required an approach that could facilitate the interpretation of the operational detail of rural health education pedagogy focusing on the techniques of power that shape students' professional and personal identities. To this end a discursive critical theory approach, which brings together theoretical concepts discourse analysis and fieldwork techniques, was used to examine the ways academics, rural health practitioners and students interact in the pedagogical space of rural health education. Many social texts combine to inform knowledge in this pedagogical space. In the quest to make some linkages between what was theoretically and experientially known about rural communities and what was being taught and learned in rural health education, several sources of data were used in this research.

Capturing and analysing the ways in which academics, rural health practitioners and students understood rural health education was central to the exploration of professional socialisation and identity formation. The

way academics, practitioners and students produced, perceived and navigated the pedagogical space of rural health education was examined through a focus on their language use, because 'language in use' constitutes social action (Gee, 1999). The collection of concrete instances of language use was achieved using three fieldwork data collection techniques. These included interviews with academics that were charged with teaching rural health education in the portfolios, key curriculum documents, interviews with health practitioners who supervised students during rural placements and field notes that arose from fieldwork observations of undergraduate nursing, pharmacy and medical students during their rural placements. These techniques were useful for constructing the texts for analysis. Critical discourse analysis, with its particular interest in the relationship between language, power and identity was used to conduct an empirical analysis of the texts.

## SIGNIFICANCE OF THE RESEARCH

The discussion in this section centres on why this research is important and what new concepts, theories and research tools and techniques it contributes to the field of rural health education.

In Australia, a great deal of time, money, energy, and expertise is being invested in rural health education as a way of overcoming the acute, yet chronic rural health workforce shortages. Fiscal and human resources are being invested in universities in order to develop a comprehensive infrastructure to support rural health education. There is some evidence to suggest that

educational experiences in rural and remote settings may address the rural health workforce shortages (Chan et al., 2005; Veitch et al., 2006). There is just as much evidence that rural exposure during undergraduate health science education has little impact on students' intentions to work rurally (Easterbrook et al., 1999; Orpin & Gabriel, 2005). These education models are expensive and require a high degree of organisation and support. If their outcomes do not adequately work to attract future graduates to rural practice this same level of investment may not continue. If this occurs, there is a risk that many rural health education initiatives are unlikely to be sustained, which in turn may worsen the marginalisation of rural populations. This research makes a significant contribution to the understanding and practice of rural health education in undergraduate nursing, medical and pharmacy education. These understandings are crucial for improving rural health education as an effective rural health workforce supply strategy.

There are concerted efforts to develop rural health education in meaningful ways that will advance the agenda of increasing and sustaining the rural health workforce. The development, implementation and evaluation of rural health education currently takes place in many schools of nursing, medicine and pharmacy. The practical nature of these activities is reflected in the methods and methodologies that are currently being used to formulate ways of advancing rural health education in the undergraduate programs and measuring its assumed outcomes. Defining rural health education as a rural health workforce

preparation and supply strategy can be understood as a 'normative activity' (Burbules & Berk, 1999). Some aspects are selected and emphasised (rural practice intentionality) at the expense of others (relations of knowledge, discourse and power). Generating deeper understanding of these selections and exclusions will be a helpful resource for educators and researchers who are involved in developing and studying rural health education.

There is an urgent need for rigorous empirical research into the effectiveness of rural health education as a rural health workforce supply strategy (Ranmuthugala et al., 2007). This research examines the micro politics of power, the way language produces rural people, places and practice in particular ways. It also considers how these constructions influence undergraduate nursing, pharmacy and medical students' personal and professional identities through a process of professional socialisation. In doing so, it introduces new conceptual, theoretical and methodological resources that can be used to engage effectively with the themes and concerns of contemporary Australian rural health education and research. The study is significant because, in line with the emancipatory interest of all critical studies, it makes visible the taken for granted assumptions that underpin the official and hidden dimensions within the pedagogical space of rural health education. This suggests that language may have a more significant role in shaping the socialising process of rural health education and students identity formation than has been previously acknowledged. Critical discourse analysis has an important contribution to make



to research on the transformations that are necessary for attracting students to rural practice. As such, this research involves original and critical enquiry that makes a significant contribution to existing knowledge of relevance both nationally and internationally.

The shortage of rural health professionals is a complex issue that requires significant resources to be applied at various levels (Hutten-Czapski & Haileybury, 1998). There is no magic bullet solution to these problems (Barer & Stoddart, 1999). The value of the analysis in this work, however, lay in its contribution to current understandings of rural health education and what is required to improve them as a rural health workforce preparation and supply strategy. At the same time, in all research there are boundaries that must be acknowledged. These boundaries are the focus of attention in the next section.

## SCOPE OF THE RESEARCH

The research was concerned with the cultural construction of rural communities in rural health education and how the process of professional socialisation influenced student's identity formation. As such, the study is typical of qualitative research. The purpose of qualitative research is to provide rich descriptions of the social world to allow for a deeper understanding of the phenomena under study (Denzin & Lincoln, 2006). To achieve this, a small purposive sample allowed for rich, thick descriptions that permitted a contextual understanding of the day-to-day operation of health education to be generated. From these descriptions of rural health education as a process of

professional socialisation readers are encouraged to "... determine how closely their situations match th[is] research situation, and hence, whether [these] findings can be transferred" (Merriam, 1998, p 211).

Ideally, the socialising influence the broader undergraduate nursing, medical and pharmacy curriculum may have on the learnings students acquire from rural health education should be studied over time. This would involve studying a cohort of first year students and following them through their undergraduate program until graduation. While such research would involve a longitudinal study, this investigative style of tracking students has already been established within the field of rural health education (Orpin & Gabriel, 2005). This study, however, was undertaken in a particular historical period during the students overall professional socialisation period. By doing so, this study managed to achieve a detailed account of the way language is used by socialising agents to construct and deliver rural health education. The findings suggest that the language of rural difference and disadvantage that is so taken-for-granted for talking about rural communities may be negatively influencing student's perceptions of their rural health education experience. Furthermore, the way rural communities are constructed in discourses of rural idyll and ordeal may inevitably contribute to their ongoing marginalisation.

Finally, it is necessary to acknowledge the socially constructed nature of interpretations is foundational to this research. This means the information shared by the academics, health professionals and students may also

have been influenced by their pre-existing world views and experiences (as has the researcher). Likewise the extent to which the reader engages with the findings presented in this study will also be influenced by their own worldview of rural health education.

The participant observation and interviewing approaches to data gathering in this study have yielded an in-depth and intensive understanding of the particular aspects of rural exposure. Chapters 5, 6 and 7 show how these particular aspects of rural health education can influence student attitudes toward rural practice. While it is important to appreciate each setting as a unique context, the study may offer some general insights relating to socialising agents constructing the cultural conditions that support or countervail a culture of teaching and learning conducive to attracting students to rural practice. It may also offer some general insights into the way undergraduate students navigate those conditions as they professionally develop as emerging health professionals who are making important career planning decisions.

## OUTLINE OF THE THESIS

In addition to opening this thesis and defining some key terms, this chapter has considered rural health education within its broader disciplinary field of rural health. Two changes relating to differences and shifts in focus over time within the field of rural health and also the field of knowledge studies suggest the need to reconceptualise rural health education. Rural health education is generally understood as a rural health workforce supply

strategy. In this study, however, rural health education is conceptualised as a contested pedagogical space with permeable boundaries. It is within this space that groups from various disciplines construct and convey knowledge and identity-making possibilities. This new way of conceptualising rural health education offers a new way to examine the day-to-day practices of rural health education in undergraduate nursing, medical and pharmacy programs. As such, outcomes that have not been previously considered, such as undergraduate student identity formation, can now be examined. In turn, the deep insights into the nature, practice and outcomes of rural health education allow for some consideration of its enabling and constraining possibilities as a rural workforce supply strategy.

In chapter two, rural health education literature is reviewed for two reasons. First, to situate this study in the body of scientific and expert knowledge, and second, to use the literature as a data source to examine how it is mainly constructed by rural health educationalists and researchers. The literature review findings show that much of rural health education research has been guided by a positivistic paradigm. The nature of classic experimental study design tends to abstract phenomena from its context in order to examine it. This has resulted in rural health education primarily being discussed independent of its relationship with health science education and rural practice. In this chapter, the discussion uses the concept of the pedagogical space to examine how rural health education knowledge intersects with other fields of disciplinary

knowledge. These insights are crucial for identifying new ways of looking at rural health education, and extending methodologies for researching this subject to build on what is currently known.

Chapter three outlines the theoretical underpinnings of the research and organises the key theoretical perspectives within a research framework for the remainder of the thesis. To do this, the concept of professional socialisation is used to theorise rural health education as a process of socialisation-as-interaction. Personal and professional identity is advanced as a new way for examining the outcomes of rural health education. Theories of power, discourse and identity are used to design a theoretically informed conceptual framework that draws on notions of space and boundaries. Finally, an overview of the principles of critical discourse analysis (CDA) are presented and justified.

Chapter four examines the practical methods and techniques of capturing and analysing the contested pedagogical space for rural health education. Procedures for setting up the study are described. These included, identifying the data sources, sampling procedures, ethical considerations and the process of negotiating access to the study sites. The data collection techniques of fieldwork (observation-of-participation, field notes, field interviews and a reflexive diary) are outlined. A detailed account of the ways data were analysed and how rigour was maintained is also provided in this section.

Chapter five examines the language used by health science academics and rural health practitioners that are charged with teaching rural

health education and facilitating students during rural placements. The analysis focussed on the way these groups understand, and justify, their contributions to rural health education. It also focuses on the way rural people, place and practice is constructed in the academics and practitioners everyday patterns of language use. The findings show that rural health education is understood as a component of the generalist core curriculum and also as a rural health workforce recruitment strategy. There does not appear to be a body of knowledge known as rural health and this appears to give rise to a hidden curriculum that constructs rural communities as the medicalised and disadvantaged 'other'.

Chapter six examines the boundaries and production of knowledge and identity-making possibilities in the pedagogical space of rural health education during the rural placement. The findings of the CDA of health professional interviews and field notes taken during students rural placement show the student understand rural health education as an opportunity to develop as emerging generic health professionals that may or may not be interested in rural practice. The rural placement made three identities available for students to take up or resist. These included, 1) an emerging health professional identity, 2) a student identity and 3) a rural identity.

Chapter seven discusses the research findings and uses hidden curriculum theory to advance theoretical explanations of why rural health education is unlikely to meet its goal of rural health workforce recruitment. It does this by reformulating the research findings as rural health

education problems. These problems are discussed in terms of improving the integrity of rural health education as an education program and potential to be a successful rural health workforce supply strategy. The hidden curriculum in rural health education is discussed and ways of dealing with its presence are offered.

The concluding chapter synthesises the findings and interprets them in relation to the key research questions. The principle argument suggests that current delivery of rural health education, and the discourses that influence and support it, contribute to the development of a personal and professional identity in which students are at ease in a framework that normalises urban primacy and rural difference. In this instance it appears that rural health education is therefore working against its best intention: while students may be developing as able health professionals they are not necessarily emerging as health professionals who will be willing to work in rural areas. In this chapter an overview of the study strengths, limitations and future directions is presented. Recommendations for further research are also suggested.

## CHAPTER 2      REVIEW OF RURAL HEALTH EDUCATION LITERATURE

### INTRODUCTION

Current understandings of rural health education have been useful for developing and establishing ways of advancing rural curricula in undergraduate health science education. Many of these models are being used to prepare nursing, medical and pharmacy students in ways that may generate their interest in rural practice. The literature in rural health education tracks the changing perspectives. It is therefore a rich source of data for examining the ways government, researchers and educationalists construct rural health education. In this chapter, the findings of a review of rural health education literature are presented.

The review was undertaken with two purposes in mind. Firstly, to situate this study in the body of scientific and expert knowledge. Secondly, to treat the literature as a data source for answering the first research question: *How is rural health education constructed within the rural health literature?* As such, there are three main sections in this chapter. The first section presents a brief overview of the methods and procedures undertaken to conduct the review. The second section examines focussing on language as it is used by various groups—from government to educators to researchers — to construct a reality that works to support the political ideology of strengthening the rural workforce.



The third section presents a synthesis of the key themes that emerged from the literature review and uses theories of professional socialisation to offer some theoretical explanations of what is already known within rural health education.

## SECTION 1. LITERATURE REVIEW METHODS

The criteria used to select and analyse the themes presented in the literature review are outlined in this section. In line with the critical stance that is taken in this study, the methods used in the review of rural health education literature were based on an epistemological position that recognises its historical, cultural and temporal nature. In this study, knowledge about rural health education is understood as being historically and culturally specific. Considering knowledge about rural health education to be a product of culture situated in a particular historical period influenced the review procedures in two ways.

Firstly, knowledge about rural health education could not be seen to be separate to the contexts of its production. As such international and Australian literature was searched and analysed as partial context specific contributions to knowledge rather than assumed as a whole body of knowledge about rural health education. Furthermore, the health disciplines from which rural health education knowledge has emerged have also been considered in terms of being parts of the whole contribution.

Secondly, it was necessary to include literature across a wide time span in order to analyse the dynamic evolution in knowledge about rural health education. The literature search was carried out between January 1970 and June 2007 using the CINAHL, Synergy, Medline, Cochrane databases and Google scholar. References were also retrieved from author lists. The search terms include 'rural', 'health', 'education', 'placements', 'students' and these were used in various combinations. The criteria used to base decisions on including and excluding articles from the review process are presented in Table 1. English language papers only were retrieved.

Inclusion Criteria	Scope	Time, place & language	Study type
Descriptions of rural health education	Papers that were referred to, by authors writing about rural health education, as evidence that rural health education is a rural health workforce strategy.	Be reported and published in English, and	Papers that were: Editorials
Level of rural health education interventions	Papers that describe or discuss programs that advance rural health education in higher education programs.	Be published in the period of 1970-2007	Program descriptions and or evaluations Literature reviews
Knowledge and meaning in rural health education	Papers that describe the pedagogical detail and curriculum content in rural health education.		Non-empirical papers Text books
Measures of rural health education outcomes	Papers that report outcomes measures of rural health education.		
Obscure perspectives in rural health education	Papers that make discreet references to alternative comments or views of rural health education.		
Exclusion Criteria	Scope	Time, place & language	Article type
Level of rural health education intervention	Papers that were about post graduate rural health education interventions or professional development.	Not reported or published in English, and	All types of articles were included
Discipline perspective of rural health education	Rural health education in disciplines other than nursing, medicine and pharmacy.	Not published during the period of 1970-2007	

**Table 1111, Inclusion and Exclusion Criteria for Literature Review**

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A total of 286 papers were classified in two ways. The methodological orientation of each paper was assessed using the categories a) opinion article b) research report c) program description and/or evaluation d) text book and e) literature review. The majority of papers appear to employ scientific research methods to generate knowledge. The discipline perspective of each paper was established using the categories a) medicine b) nursing c) pharmacy and d) interprofessional. The majority of papers are written from a medical perspective.

## SECTION 2. KNOWLEDGE ABOUT RURAL HEALTH EDUCATION

A detailed content analysis of the literature examining what is known about rural health education is presented in this section. It is organised within the following themes; ‘defining rural health education as part of the rural health workforce strategy’, ‘advancing the rural health workforce agenda through higher education’, ‘knowledge- making and the pedagogical space of rural health education’, and the ‘measured outcomes of rural health education’.

### *DEFINING RURAL HEALTH EDUCATION AS A RURAL HEALTH WORKFORCE STRATEGY*

The literature search uncovered a total of 53 (19%) articles that focus on increasing the number of rural background students in health science programs as a way of responding to the rural health workforce shortages. The majority of these papers are research reports, as presented in Table 2, which are written from a medical perspective, as presented in Table 3.

Paper Type	Percentage
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Opinion papers	7 (14%)
Research reports	35 (64%)
Program descriptions/evaluations	10 (19%)
Literature reviews	0
Text books	1 (2%)

**Table 222, Breakdown of papers by type for theme defining rural health education as a rural health workforce strategy**

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Discipline	Percentage
Nursing	12 (23%)
Medicine	41 (77%)
Pharmacy	0
Interprofessional	0

**Table 333, Breakdown of papers by discipline for theme defining rural health education as a rural health workforce strategy**

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### Factors that attract or deter health professionals to rural practice

Health professional's decisions to take up and remain in rural practice are driven by a variety of social, cultural, professional, economic, and personal factors. Cultural factors include racial-ethnic status (Xu et al., 1997) and growing up in a rural area (Asuzu, 1989; Easterbrook et al., 1999; Hegney et al., 2002; Lea & Cruikshank, 2005; Matsumoto et al., 2005; Rourke et al., 2005; Xu et al., 1997). Social factors, such as lifestyle opportunities, not only for health professionals but also for their spouse and children can either attract or detract health professionals from living and working in a rural community (Anderson et al., 1994a; Brown et al., 1990; Chiasson et al., 1995; Fickenscher, 1992;

Homan, 1994; Lahaie, 1991; Piterman & Silagy, 1991; Rabinowitz & Paynter, 2002; Rosenblatt et al., 1992; Rourke, 1993). Professional factors, such as the quality of partners in practice, call schedule and familiarity with the workplace as well as employer and community recognition, (Courtney et al., 2002) are also known to influence health professional's decisions about rural practice. So too, do various economic factors. For instance, it is known that health professionals who experience less financial burden after graduation are more likely to take up rural practice (Xu et al., 1997). This may be one reason why loan and scholarship recipients tend to take up rural practice (Mattson et al., 1973; Pathman & Riggins, 1996).

Some studies have found that health professional's decisions to live in a rural area and work in rural practice are influenced by a personal interest in rural life and health. Many health professionals have reported these interests existed prior to undertaking their health career studies (Xu et al., 1997). Others indicate these interests were developed during their health professional education and training through various rural health education interventions (Dunkin et al., 1997; Hegney et al., 1997; Huntley, 1995; Lea & Cruikshank, 2005; Magnus & Tollan, 1993; Matsumoto et al., 2005; Rourke et al., 2005; Wearne & Wakerman, 2004; Wilkinson et al., 2003; Wood, 1998; Xu et al., 1997) or continuing professional development opportunities (Courtney et al., 2002; Ebbesson, 1988; Rourke et al., 2005). Some studies find that it is not one factor but rather a multitude of factors that interact to influence a health professional's decision to

practice in rural areas (Britt et al., 1993; Cooper et al., 1977; Laven et al., 2002).

Knowledge about what attracts health professionals to rural practice has allowed researchers to identify a contingent relationship between various social processes and rural health workforce recruitment. Studies show that while a small percentage of new graduates enter practice in rural and remote areas, this rural uptake can be improved with more rural health education, professional development and continuing education opportunities (Francis, 2002). Others find rural health education activities have no explanatory effect on health professionals rural practice decisions (Pathman et al., 1999). Nevertheless, these studies are now being used to develop strategies that are regarded as conducive to building a stronger rural health workforce. This has given rise to a growing body of literature that is seeking to identify factors that may be predictive of students' rural intentionality<sup>13</sup>.

In many studies there are attempts to make associations between particular attributes and undergraduate students rural practice intentions. Three key attributes that have been examined include gender, rural background and rural educational experiences (Woloshuk et al., 2005). Of these attributes, most research shows that growing up in a rural area to be the sole independent predictor of rural practice (Azer et al., 2001; Bushy & Leipert, 2005; Carline et al., 1980; Craig et al., 1993; Fry & Terry, 1995; Laven et al., 2002; Masatoshi et al., 2005; Owen et al., 2007; Playford et al., 2006; Rabinowitz et al., 1999a; Rabinowitz

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<sup>13</sup> Studies measuring student claims of rural intentionality as an outcome of rural health education are discussed on page [1073](#) of this chapter.

et al., 1999b; Rourke et al., 2005; Smith et al., 2001; Travernier et al., 2003; Ward et al., 2004; Woloshuk et al., 2005; Woloshuk & Tarrant, 2002; Woloshuk & Tarrant, 2004; Wood, 1998). Nevertheless, there are strong indications that rural educational experiences may also generate student's interest in rural practice (Reimer & Mills, 1988). Research also shows that women are less inclined toward rural practice than men (Levitt & McEwin, 2002). While a variety of factors appear to influence students rural practice decisions in some way or another, it has been established that no one single influence can be absolutely indicative of students' rural practice intentionality (Somers et al., 2001; Tolhurst & Stewart, 2003; Tolhurst & Stewart, 2004).

#### *ADVANCING THE RURAL HEALTH WORKFORCE AGENDA THROUGH HIGHER EDUCATION*

Educationalists are now experimenting with various initiatives to increase the undergraduate nursing, pharmacy and medical student's interest in rural practice as a positive and viable career option. Within this theme, the literature search uncovered a total of 186 (65%) articles. The majority of these papers are program descriptions and/or evaluations, as presented in Table 4 and mostly written from a medical perspective, as presented in Table 5.

<b>Paper Type</b>	<b>Percentage</b>
Opinion papers	42 (23%)
Research reports	54 (29%)
Program descriptions/evaluations	88 (47%)
Literature reviews	2 (1%)

Table ~~4444~~. Breakdown of papers by type for theme advancing rural health education in higher education

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Discipline	Percentage
Nursing	40 (22%)
Medicine	141 (76%)
Pharmacy	3 (2%)
Interprofessional	3 (2%)

Table ~~5555~~. Breakdown of papers by discipline for theme advancing rural health education in higher education

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The analysis of this body of literature shows there are three main ways the rural health workforce agenda is being advanced in undergraduate nursing, pharmacy and medical education. These include initiatives to a) attract rural youth to health science careers, b) admit greater numbers of rural background students to medical schools, and c) provide large numbers of undergraduate students with opportunities to learn about and experience working in a rural community. Each of these themes will now be presented in the following sections.

### **Attracting rural background students to health science careers**

Rural and remote students are under-represented in higher education participation in almost all health career fields. Research shows the reasons for this include a) lower parental education or schooling education



(Adenorff et al., 2001; Heaney, 1998), b) lower levels of students completing secondary education (Lamb, 1998) c) the distance costs associated with attending university (Durey et al., 2003; Durkin et al., 2003; Heaney, 1998; James et al., 2004; Jones et al., 2005; Neill & Taylor, 2002; Pathman et al., 2000; Rourke et al., 2005), c) motivation (Heaney, 1998) and d) separation from family and friends (Durey et al., 2003; Durkin et al., 2003; James et al., 2004). While rural youth may be interested in health careers (Atkinson et al., 2003), it appears they are unsure of how to move forward to gain entry into the undergraduate programs. As well as rural and remote students being under-represented in all undergraduate health science programs, this occurs at all levels (Coates & Krause, 2005; Dhalla et al., 2002; Hays et al., 2006; Nugent et al., 2004; Rourke et al., 2005). Health careers do not appear to be attracting enough students from rural areas therefore various measures are now being implemented in universities to improve rural students' access to health science education.

There is a recognised need to increase the number of rural youth to be recruited into health science careers (Babbie, 2001; Barer & Stoddart, 1999; Dhalla et al., 2002; Durey et al., 2003; Hamilton, 1995; Jackson et al., 1993; Kamien & Buttfield, 1990; Kaufman, 1990; Khadra, 2001; Norington, 1997; Rourke, 1993; Vanselow, 1990). Strategies for achieving this include careers promotion days (Gill & Tonks, 1996), videos for rural high school students (Rafuse, 1994), Commonwealth funded scholarship programs (Mak & Plant, 2001), mentors (Hamilton, 1995), rural outreach programs (Johnson & Haughton, 1975; Shack,

1999), rural health careers clubs in high schools (Bruce, 1985; Jackson et al., 1993) and support programs for career and guidance counsellors and advisors (Barer & Stoddart, 1999; Hutten-Czapski & Haileybury, 1998).

As well as attracting rural youth to health careers, many programs assist them to access these courses. For instance, a number of programs assist rural high school youth to become more competitive contenders in their applications to university (Crump et al., 2002; Kamien & Buttfield, 1990; Knopke et al., 1986; Ramsey et al., 2001; Shack, 1999). Other schools of medicine have amended their admissions policy to given special preference to rural background students (Dunbabin & Levitt, 2003). Some international researchers argue that recruiting rural background students to undergraduate medical programs is such a strong way of increasing rural health workforce supply that any school policy that does not support rural background student entry may be unsuccessful (Rabinowitz et al., 1999b).

### **Admitting rural background students to medical schools**

The historical admission procedures for students to gain entry to health professional education are recognised as structural impediments to rural student's access to higher education (Basco et al., 1998; Cullison et al., 1976; Rabinowitz, 1988a; Rabinowitz, 1988b). Many international schools of medicine have amended their admission policies and procedures to preferentially admit rural background students as a way of increasing their access to higher

education. Early research shows rural origin students facing admissions process were significantly disadvantaged because a) most medical school admission committees have no rural members and b) do not have a policy or strategy for rural admissions (Cullison et al., 1976; Rabinowitz, 1983; Rabinowitz, 1988a; Rabinowitz, 1988b; Rabinowitz, 1993; Rourke et al., 2005).

Some international schools now have an established track record for choosing candidates who are likely to desire practice in a rural area, even though their academic credentials may be below that of students normally admitted (Mattson et al., 1973; Rabinowitz, 1988a; Rabinowitz, 1988b; Rabinowitz, 1990; Stearns et al., 2000; Woloshuk & Tarrant, 2002). In addition to rural background, some schools assess student's career preferences and selectively admit students who are inclined toward rural practice (Boulger, 1980; Boulger, 1991; Brazeau et al., 1990; Rabinowitz, 1988a; Rabinowitz, 1993; Verby et al., 1991) or rural health education pathways (Boulger, 1991; Kaufman et al., 1980).

During the 1990s, Australian medical schools recognised the need for affirmative action in terms of admission policies (Hickner, 1991b) and sought to implement strategies designed to be more inclusive of rural student's participation in higher education. For instance, the RUSC (Rural Undergraduate Steering Committee, 1994) program now requires that 25% of enrolled medical students have a rural background for schools to qualify for funding. Consequently, most Australian medical schools have amended their selection criteria (Adenorff et al., 2001; Dunbabin & Levitt, 2003) and there is

now some evidence that the number of rural background students is increasing in medical programs (Azer et al., 2001; Laurence et al., 2002). There are no Commonwealth funded schemes that assist schools of nursing or pharmacy to increase the number of rural background students in their undergraduate programs. This may be one reason why there is no evidence of admission procedures having changed to preferentially admit rural students to nursing or pharmacy programs.

### **Providing undergraduate nursing, medical and pharmacy students with rural experiences**

Many schools of nursing, pharmacy and medicine have amended their teaching and learning program, to increase the rural focus in their undergraduate curricula. The predominant change in terms of rural curricula reform appears to be the inclusion of rural attachments (Billings, 1979; Blue et al., 2004; Blue et al., 2001; Gower & Simkin, 2000; Hofwegen et al., 2005; Jones et al., 2000; Lynch & Willis, 2000; Mackintosh & Ross, 1978; McDonough et al., 1992; Medves et al., 2006; Pfundstein, 1999; Potts, 1994; Reimer & Mills, 1988; Schauer & Schieve, 2006; Snadden & Bates, 2005; Yadav, 2003; Zinser & Wiegert, 1976; Zorzi et al., 2005). These are also known as rural placements, rural exposure and rural rotations. In general, rural attachments are short term, rural community-based rotations that provide students with the opportunity to experience rural practice under the supervision of rural health professionals (Gregory et al., 2006). Instead of being stand alone rural health education models, they usually form part of other units within undergraduate nursing, medical and pharmacy

programs. While most rural attachments are discipline specific, there is a growing trend for students from a variety of disciplines to undertake rural placements together (Bellack et al., 1997; Borrego et al., 2000; Geller et al., 2002; LaSala, 2000; LaSala et al., 1997; LaSala et al., check; Rhyne et al., 2006; Shannon et al., 2005; Slack et al., 2002; VanLeit & Cubra, 2005). Some medical schools have also developed rural health education programs that are models in their own right.

Internationally, many medical schools have developed and implemented educational programs that are distinctively rural curricula (Mackintosh & Ross, 1978; Wood, 1998). The more notable rural health education programs that feature rural curricula and initiatives that provide medical students with extended and extensive experiences of rural practice include:

- Rural Physician Action Plan [Alberta], (Moores et al., 1998; Wilson et al., 1998)
- Rural Physician Associate Program Plan [Minnesota] (RPAP), (Chaytors & Spooner, 1998; Foreman et al., 1976; Garrard & Verby, 1977; Halaas, 2005a; Halaas, 2005b; Heid, 1979; Moores et al., 1998; Verby, 1988; Verby & Connolly, 1972; Verby et al., 1991; Wilson et al., 1998)
- Queens Rural Medical Initiative, (Gower & Simkin, 2000)
- (WAMI), (Adkins et al., 1987; Carline et al., 1980; Dimino, 1992; Ebbesson, 1988; Elder & Amundson, 1991; Hart et al., 1991; Jackson & Daly, 2004;

Joseph, 1976; Kobernick, 1975; Lishner et al., 1991; Ramsey et al., 2001; Riley & Elder, 1999; Rosenblatt, 1991; Schwarz, 1979)

- Rural Medical Education (RMED), (Stearns et al., 2000)
- New Mexico Plan: Primary Care Curriculum (Kaufman, 1990; Kaufman et al., 1980; Urbina et al., 2003)
- Family Practice Preceptorship Program, (Boulger, 1980; Boulger, 1991)
- Rural Alabama Health Professional Training Consortium, (Leeper et al., 2001)
- Physician Shortage Area Program PSAP (Barnett & Larson, 1978; Rabinowitz & Paynter, 2000)

The defining feature of these stand alone rural health education models is the 'pipeline' philosophy. These models emphasise three key areas, being a) the importance of recruiting future rural health professionals from rural settings to health careers, b) the need for rural exposure in the undergraduate program, and c) the role of rural exposure in the post graduate period (Callahan, 1962; Curran et al., 2004; Curran & Rourke, 2004; Norris, 2005; Rabinowitz & Paynter, 2000; Tepper & Rourke, 1999). The rural pipeline model is now recognised as a critically important rural health preparation and supply strategy that has universal relevance (Norris, 2005; Pathman et al., 1999).

While not all international schools subscribe to the rural pipeline philosophy, there are many other rural health education models. Rather than a collection of initiatives that infiltrate all aspects of a health science

program, these models tend to be topic areas or subjects that appear in undergraduate nursing, medical and pharmacy programs (Barnett & Larson, 1978; Cooper et al., 1977; Hofwegen et al., 2005; Inoue et al., 1997; Medves et al., 2006; Reimer & Mills, 1988; Rourke, 2002; Snadden & Bates, 2005; Stratton et al., 1991; Traynor & Sorenson, 2006; Yadav, 2003). Although many countries are far more experienced in rural health education in terms of rural placements, stand alone models and rural topic areas, Australia has been able to benefit from these experiences.

Rural health education initiatives in Australia are becoming internationally recognised as innovative and strategically coordinated. According to Hays (2005), successful rural health education requires a) a planned rural curriculum, b) relevant assessment criteria, c) academic staff situated in the rural context, d) information and communication services, e) selected cohort of students who are interested in rural practice, and f) travel and accommodation assistance (Hays, 2007). For these reasons, many schools have made structural alterations to their undergraduate programs to increase enrolments of rural background students and provide large numbers of students with rural health education teaching and learning experiences.

Over the past decade, most Australian schools of nursing, medicine and pharmacy have amended their existing undergraduate programs to include more opportunities to expose students to rural people, places and practice (Brazeau et al., 1990; Courtney et al., 2002; Gill & Tonks, 1996; Gum, 2007; Hays,

1990; Hays, 2001a; Hays, 2001b; Hickner, 1991a; Hutchinson, 1984; Jones et al., 2003; Laurence et al., 2002; Laurence & Wilkinson, 2002; Lawson et al., 2000; Liaw et al., 2005; Lockhart et al., 2003; Lyle et al., 2006; Mak & Plant, 2005; Murphy et al., 1994; Worley et al., 2000). Just as there is diversity in the form that international models of rural health education can take, there are many forms of rural health education in Australia.

One feature that distinguishes rural health education in Australia is the Commonwealth governments support to ensure large numbers of students undertake some aspects of their undergraduate study in a rural area. A number of funded medical and rural schools now have explicit regional and rural missions (Hays, 2007; Strasser, 2005; Walters & Worley, 2006) and many others have amended their programs to include comprehensive models of rural health education (Hays, 2001a; Hays et al., 1994; Margolis et al., 2005; McAllistair et al., check; Rosenthal et al., 2004; Strasser, 1993; Strasser, 2002; Sturmberg et al., 2001; Sturmberg et al., 2003; Veitch et al., 2006; Walters et al., 2003; Worley & Lines, 1999; Worley et al., 2000; Worley et al., 2004c). Through the Rural Clinical Schools initiative, the Australian Government now ensures that 25% of all Australian medical graduates have completed at least twelve months of their undergraduate program in rural and regional communities (Commonwealth Department of Health & Aging, 2005).

In order to exposure large numbers of students to rurality, the majority of Australian schools use the rural placement model (Armitage &



McMaster, 2000; Bruening & Maddern, 2003; Courtney et al., 2002; Critchley et al., 2006; Hays, 2005; Hollins et al., 2001; Hutchinson, 1984; Jones et al., 2003; Larson et al., 2004; Lionis & Wynn-Jones, 2007; Margolis et al., 2005; Martyr et al., 1999; McAllistair et al., 1992; Neill & Taylor, 2002; Peach & Barnett, 2000; Peach & Bath, 2000; Playford et al., 2006; Rolfe et al., 1995; Rosenthal et al., 2004; Smedts & Lowe, 2007; Wilson & McHardy, 2004). While most rural placements are discipline specific, some have been designed to accommodate students from a number of different professions (Albert et al., 2004; Dalton et al., 2003; Liaw et al., 2005; Lockhart et al., 2003; Lyle et al., 2006; McNair et al., 2001; Playford et al., 2006). A national survey of Australian rural nurses found that only 8% had experienced any fieldwork in rural practice during training (Stephenson et al., 1999). More recently, a survey of nursing schools in South Australia found that five schools (71%) offer rural placements for undergraduate students (Laurence & Wilkinson, 2002).

Rural placements appear to have two intended purposes. Firstly, it is expected that rural placements should provide students with a comprehensive understanding of health needs in rural areas. Secondly, rural placements are a way of generating students' interest in future employment in rural settings (Hays, 1992; Hays, 2001a; Hays, 2001b; Hays et al., 1996; Laurence et al., 2002; Laurence & Wilkinson, 2002; National Rural Health Alliance, 2004; Playford et al., 2006; Wilkinson & Blue, 2002; WONCA, 1996). In order to achieve these goals, educationalists are seeking to immerse students into rural life to make

connections with the community and setting (Denz-Penhey et al., 2005; Denz-Penhey et al., 2004; Khadra, 2001; Liaw et al., 2005; Murphy et al., 1994; Topps et al., 2003; Wakerman & Humphreys, 2002; Worley & Lines, 1999; Worley et al., 2004b; Worley et al., 2000; Worley et al., 2004c). Some commentators (Denz-Penhey et al., 2005; Halaas et al., 2007; Margolis et al., 2005) argue the acquisition of rural knowledge, beliefs and values can only be achieved through longer rural rotations. For instance, Denz-Penhey (2004, p 2) argues, "... the opportunity to acculturate students into the rural lifestyle is lost when student placements are insufficiently long for them to put down roots in their community and to understand how to 'live' there more broadly".

The transmission and acquisition of rural knowledge, beliefs and values appears to be the crucial component of rural exposure for attracting students to rural practice. Perhaps this is why Australia has invested so heavily in establishing a network of clinical schools and departments in rural locations.<sup>14</sup> Some commentators have tried to distinguish rural schools from urban schools on the basis of geographic location and curriculum delivery (Tesson et al. 2005). Three different types of schools are described as, mixed urban/ rural schools, defacto/rural schools and stand alone rural schools (Tesson et al., 2005). These models allow undergraduate nursing, medical and pharmacy students to undertake greater degrees of their studies in the rural setting.

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<sup>14</sup> For more details on the Rural Clinical School and University Department of Rural Health network in Australia, please refer to page [273](#) of the introductory chapter.

Vast geographic distances present rural health educationalists with delivery challenges that are not always a concern in undergraduate nursing, pharmacy and medical education that predominately use urban-based teaching hospitals for student's clinical placements. Particular teaching and learning principles are therefore recognised as crucial for the delivery of rural health education. These include community-based education (Khadra, 2001; Norington, 1997; Strasser, 1992), problem based learning (Geller et al., 2002; Margolis et al., 2005; VanLeit & Cebra, 2005), flexible delivery models (Hays, 2005), adult learning principles (Mak & Plant, 2005) and experiential learning principles (Laurence et al., 2002). So too are particular delivery mechanisms that can be effectively used for rural health education programs such as web based teaching and learning resources (Baker et al., 2005; Godden & Aaraas, 2006; McGrail et al., 2005) and videoconferencing (Newbury et al., 2005).

Although rural health education is now available there is evidence that not many undergraduate health science students are choosing to be involved. For instance prior to 1992 the Parallel Rural Community Curriculum (PRCC) was offered as an elective but fewer than 5% of students chose this experience and the 1992 decision to require the clerkship of all students was met with widespread disgruntlement and resentment among students of whom were required to take the clerkship in the academic year 92-93 (Jones et al., 2000). Rural background, previous work experience in a rural community and family, financial and or employment commitments all influence student's choice of undertaking or not

undertaking voluntary rural clinical placements (Smith et al., 2001). Furthermore, others (Zaidi, 1986) report that students will not take up rural placements if they believe there are limited facilities, such as inadequate levels of clinical educator support (Rose, 2005) that may disadvantage their examination performance (Hays et al., 2005). Students may be reluctant to participate in rural placements because they do not have the confidence or competence necessary for rural practice (Edwards et al., 2004). Many students are more interested in tertiary hospital attachments than in the medical rural model (Price et al., 1994) but indicate they would go to a rural centre 'if they had to' (Bruening & Maddern, 2003).

### **Knowledge-making and the pedagogical space of rural health education**

In Australia, a great deal of attention is focussed on the need for rural health education reform, however, there are few papers that focus on the forms knowledge should take in the pedagogical space that has been created for it in undergraduate nursing, pharmacy and medical programs. Within this category, the literature search uncovered a total of 52 (18%) articles, which predominately consists of program descriptions and/or evaluations, which are presented in Table 6. The papers were mostly written from the medical perspective, which is presented in Table 7.

Paper Type	Percentage
Opinion papers	14 (27%)
Research reports	17 (33%)

Program descriptions/evaluations	20 (38%)
Literature reviews	1 (1%)

Table 6666, Breakdown of papers by type for theme knowledge-making in the pedagogical space of rural health education

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Discipline	Percentage
Nursing	40 (77%)
Medicine	9 (17%)
Pharmacy	0
Interprofessional	3 (6%)

Table 7777, Breakdown of papers by discipline for theme knowledge-making in the pedagogical space of rural health education

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In many papers, rural practice is constituted as a specialised area of professional practice (Crooks, 2004; Hegney et al., 1997; MacLellan & Que, 2001; McDonough et al., 1992; Wronski, 2003). The need for specific rural competencies to be developed for rural practitioners has been advocated (Bell & Walker, 2006; Halaas, 2005b). The notion that rural practice is unique underpins calls for educationalists to emphasise rural difference in learning and teaching programs (Baker et al., 2005; Bourke et al., 2004; Gum, 2007; Hays, 1990; Hays, 2001a; Hays, 2001b; Hays, 2002a; Hays, 2003; Hays et al., 1996; Hegney et al., 1997; Kamien & Buttfield, 1990; WONCA, 1996; Worley et al., 2004b; Worley et al., 2000; Worley et al., 2004c). Clarification of this notion of rural difference is rarely offered, which leaves phenomena such as rural life, rural practice, rural health and rural

health education open to interpretation.<sup>15</sup>

Some educationalists organise their teaching programs around a core set of concepts that are reported to be characteristic of the rural health context. These include health differentials, access to services, confidentiality, cultural safety, interprofessional teamwork (Bourke et al., 2004; Liaw et al., 2005) and disadvantage (Boulger, 1980; Eide, 1996; Yadav, 2003).<sup>16</sup> Others report they expect students to recognise ways rural practice might differ through their experiential placements (Cullison et al., 1976; Denz-Penhey et al., 2005; Denz-Penhey et al., 2004; Dhalla et al., 2002; Gower & Simkin, 2000; Inoue et al., 1997; Murphy et al., 1994; Peach & Barnett, 2000; Peach & Bath, 2000; Smith et al., 2001; Snadden, 2006; Talbot & Ward, 2000). So elastic is this notion of rural difference that it is too imprecise to aid any understanding of the complex patterns of social activity that exist in rural areas. Nevertheless, the rural setting is increasingly being recognised as a valuable learning context for undergraduate nursing, medical and pharmacy students.

It is often argued that experiential rural placements provide students with opportunities to learn about a variety of aspects of rural practice (Denz-Penhey &

<sup>15</sup> Ambiguous notions of rural difference is an important construct in this thesis. It was first introduced as a concern on pages ~~213, 423, 443, 483~~ and ~~503~~ in the ntroductory chapter. The trilogy of findings chapters (5, 6 and 7) will show how ambiguity surrounding the nature of rural difference manifests in the language used by health science academics and rural health practitioners in rural health education. In particular, chapter 6 shows how these discourses negatively influenced the way students made sense of rural people, places and practice. These are important findings for the field of rural health education because chapter 6 also shows these meanings played a key role in the way students shaped their personal and professional identities.

<sup>16</sup> Chapter 5 will show that disadvantage is one of the main constructs that is both an explicit and hidden meaning within the language used by health science academics and rural health practitioners in rural health education.

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Murdoch, 2007; Turner, 2005). There is evidence that learning in rural health care agencies may be beneficial for students to professionally develop as emerging health professionals. For instance, there are reports that the rural context is useful for students to learn about systemic pathology (Hays, 2005), clinical skills (Hays, 2005; House & House, 2000), public health medicine (Mak & Plant, 2005), mental health (Armitage & McMaster, 2000) and interprofessional teamwork and collaboration skills (Albert et al., 2004; Dalton et al., 2003; McNair et al., 2001; McNair et al., 2005). Others have written about the principles, such as the need for social justice (Dade-Smith, 2004; Dade-Smith, 2007; Hays et al., 1995) and the need to include rural people in developing rural health education (Hays, 2005; Hays, 2006; Hays et al., 1996; Hays & SenGupta, 2003; Hays et al., 2003), underpinning rural health education. As every institution operates in a different context (Hays & SenGupta, 2003; Snadden, 2006), however, much of this literature is generic. There is a paucity of knowledge about what meanings students may be constructing about rural people, rural health, and rural practice during such rural placements.

The gaps regarding knowledge production in rural health education knowledge may be related to the paucity of knowledge about what rural practitioners' actually do in rural practice. Rural health professionals have been described as 'another breed' (Ricketts, 2000) who cope with professional isolation and deal with a myriad of complex health care needs (Hegney et al., 1997). Despite many firmly held perceptions that rural practice is different there is little

systematic evidence about what rural health professionals do that is unique and different. Nevertheless some rural health education researchers maintain that it is the nature of the rural context that is different therefore students and practitioners are required to shape their knowledge, skills and competencies to reflect this distinctiveness (Baldwin et al., 1999; Denz-Penhey & Murdoch, 2007; Hegney et al., 1997; Warner et al., 2005a).

It appears there is a need to gain a more precise idea of how disciplinary institutions (schools of nursing, medicine and pharmacy, and rural health care agencies) constitute the pedagogical space of rural health education. While this may be a revealing exercise in itself, there is also a need to illuminate the way individuals (researchers, academics, health professionals and students) produce knowledge within the pedagogical space in order to influence patterns of social organisation<sup>17</sup>. It is this knowledge that shapes the socialising process for students who engage in rural health education. In turn, the socialising process of rural health education conditions the way students shape their personal and professional identities. For these reasons, socialisation and identity formation were recognised as the key determinants of students' decision to work rurally, which is discussed further in chapter 6. The next section shows that while the focus on professional socialisation and identity formation has a major

<sup>17</sup> Knowledge cannot be considered in isolation from power, and power cannot be considered in isolation from knowledge. The key theoretical arguments are listed on page 163, and briefly discussed on pages 303, 403 and 473 of the introductory chapter. These will be developed further in chapters 3 (page 1863) and 4 (page 2433).

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prominence in the humanities, social sciences and broader health science education fields, they do not have the same emphasis in rural health education.

#### *THE MEASURED OUTCOMES OF RURAL HEALTH EDUCATION*

Rural health education has been historically constituted as a rural health workforce preparation and supply strategy therefore its measurable outcomes are narrowly conceived. Within this theme, the literature search uncovered a total of 77 (27%) articles, which were mostly program descriptions and/or evaluations, which are presented in Table 8. The papers were predominately written from a medical perspective, which is presented in Table 9.

Paper Type	Percentage
Opinion papers	0
Research reports	53 (68%)
Program descriptions/evaluations	24 (32%)
Literature reviews	0

Table ~~8888~~, Breakdown by paper type for theme measured outcomes in rural health education

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Discipline	Percentage
Nursing	18 (23%)
Medicine	54 (70%)
Pharmacy	0
Interprofessional	5 (6%)

Table ~~9999~~, Breakdown of papers by discipline for theme measured outcomes

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### **in rural health education**

The Australian government is investing in rural health education initiatives with the expectation that schools of nursing, medicine and pharmacy will create a stronger rural health workforce (Angrosino et al., 2000; Australian Health Ministers' Conference, 1999; Australian Health Ministers' Conference, 2003). The majority of research and evaluations reporting the outcomes of rural health education are therefore concerned with how well current programs are working towards this goal.

There are three ways rural health education outcomes are currently measured. First, by reporting the number of graduate health professionals who may take up rural practice. Second, by reporting how well the academic performance of undergraduate nursing, pharmacy and medical students who participate in rural health education initiatives compares with those who undertake mainstream programs. Third, student's satisfaction with the quality of their learning experiences or self reports of competence achievement as a result of their rural health education experience is also being examined. The findings of these sets of literature shall now be presented.

### **Rural workforce recruitment**

The emerging evidence base for supporting rural health education as an effective rural workforce supply strategy is inconclusive. Constrained by the long lead time it takes to generate health professionals, the majority of research seeks to measure students intentions to take up rural practice as a result of rural

health education (Callahan, 1962; Courtney et al., 2002; Critchley et al., 2006; Easterbrook et al., 1999; Fry & Terry, 1995; Gum, 2007; Hutten-Czapski & Thurber, 2002; Jones et al., 2000; Larson et al., 2004; Leeper et al., 2001; Lynch & Willis, 2000; Martyr et al., 1999; Peach & Barnett, 2000; Peach & Bath, 2000; Rhyne et al., 2006; Talbot & Ward, 2000; Wilkinson et al., 2004; Woloshuk & Tarrant, 2002; Woloshuk & Tarrant, 2004; Wood, 1998; Wright et al., 2006). These studies are limited because students reported intention to practice in a rural area does not necessarily translate to actual rural practice uptake.

Longitudinal studies are underway to identify the patterns of new graduates' choice of practice location. The majority of these are tracking studies (Cullison et al., 1976; Larson et al., 2004; Orpin & Gabriel, 2005; Stratton et al., 1991; Travernier et al., 2003; Veitch et al., 2006; Ward et al., 2004). Some studies have already published their preliminary findings of students rural intentionality (Larson et al., 2004; Orpin & Gabriel, 2005; Playford et al., 2006). Others have reported on the distribution patterns and numbers of students who actually take up rural practice (Medves et al., 2006; Pathman et al., 1994; Wilkinson et al., 2001). Only one study reports the stage of career and for what period of time students intend to work in rural areas (Tolhurst, 2006). Many of the early studies reporting students' rural intentionality as an outcome of rural health education are constrained by a failure to control for independent variables (Ranmuthugala et al., 2007).

There is a body of research that measures student attitudes toward rural practice. For instance, some research reports student's perceptions of working in rural practice (Azer et al., 2001; Blue et al., 2004; Lockhart et al., 2003; Orpin & Gabriel, 2005). Others report whether students have a positive or negative attitude toward rural practice (Asuzu, 1989; Carline et al., 1980; Geller et al., 2002; Hollins et al., 2001; LaSala et al., 1997; Shannon et al., 2005; Tolhurst et al., 2006). A small number of publications report rural health education may actually be turning some students away from rural practice (Orpin & Gabriel, 2005; Zaidi, 1986). The reasons why this may be occurring may be valuable for improving rural health education as a rural health workforce strategy and therefore requires further investigation.

The hypothesis that students who study in rural locations may be more likely to take up rural practice is also being tested. The majority of these studies also focus on student's rural intentionality (Boulger, 1991; Fryer et al., 1993a; Fryer et al., 1993b; Fryer et al., 1994; Hutten-Czapski & Thurber, 2002; Playford et al., 2006; Smedts & Lowe, 2007; Traynor & Sorenson, 2006; Wilkinson et al., 2004). With a focus on actual rural uptake, some findings show that while rural clinical schools enrol fewer students and produce fewer graduates than metropolitan schools, rural clinical schools produce rural physicians (Adkins et al., 1987; Inoue et al., 1997; Rosenblatt et al., 1992; Rourke et al., 2005; Smedts & Lowe, 2007; Stearns et al., 2000; Urbina et al., 2003; Wang, 2002; Wilkinson et al., 2004). There is evidence that students who undertake longer rotations in rural areas are more

likely to be interested in rural practice (Denz-Penhey et al., 2005; Magnus & Tollan, 1993).

The emerging evidence that rural health education appears to be an effective strategy for generating health professionals who are prepared for rural practice is also inconclusive. The success of rural health education as a preparation program is being measured by examining students self reports of gaining competency in particular areas of knowledge or skills (Worley et al., 2004b). Others report rural health education outcomes by recording students opinions about the value, satisfaction and worth of rural learning experiences (Edwards et al., 2004; Kamien, 1996; Penman & Oliver, 2004; Potts, 1994; Zinser & Wiegert, 1976). Studies of students self reports of the value of learning are representative of the need for more explicit critical perspective in rural health education research<sup>18</sup>. Without such a perspective, research will continue to report ‘success’ in terms of having successfully delivered a rural health curriculum that informs students about issues (Baillie et al., 2007; Hays et al., 2006; Zorzi et al., 2005). It seems that there is not only a need for more description of the concepts and constructs of rural health education, but also of the meanings students are forming about ‘rural’ issues and how these are influencing their career decisions. Rather than focussing on this interpretative dimension of rural health education, the majority of the literature appears to focus on establishing the rural context as

<sup>18</sup> The need for this study to be organised within a critical orientation was first introduced in the introductory chapter of the thesis ~~243, 373, 693, 723~~. It will be further developed in chapters 3 and 4, and applied in chapters 5, 6 and 7.

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an appropriate learning context for undergraduate nursing, medical and pharmacy students.

### **Rural contexts as appropriate learning environments**

The value of rural contexts as appropriate learning environments for undergraduate nursing, pharmacy and medical students to develop their knowledge, skills and attitudes is often reported in the rural health education literature. Many commentators argue that rural communities are effective learning environments for students to learn about general clinical and professional knowledge and skills (Garrard & Verby, 1977; Irigoyen et al., 1999; Kamien, 1996; Worley et al., 2004b). Students self reports about the value of their rural learning experiences suggest the rural context is conducive for learning about managing common conditions and procedures (House & House, 2000; Shannon et al., 2005; Zinser & Wiegert, 1976). In line with contemporary health science education, many rural health education models centralise notions of patient-centredness and holistic approaches to care (Hays, 2005; Margolis et al., 2005; Sturmberg et al., 2001; Sturmberg et al., 2003; Worley & Lines, 1999).<sup>19</sup> Many rural health education studies support the convincing argument that rural context provides students with experiences that are conducive to the development of students' as generalist health professionals<sup>20</sup>. However, other

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<sup>19</sup> Chapters 5, 6 and 7 will show patient-centredness and holistic approaches to care are difficult ideals to achieve in the busy rural practice context.

<sup>20</sup> Generalist health professional education was a core concern of the undergraduate nursing, medical and pharmacy programs at the university participating in this study. Chapters 5, 6 and 7 will show how this primary objective in the undergraduate programs shaped the way rural health education could and could not be constructed by health science academics.

than evidence that rural exposure may lead to rural uptake, more detail is required to show how students learning in the rural context may be beneficial to rural health.

Examinations of students' academic performance in rural health education shows the rural environment to be a learning environment that is as comparable with mainstream teaching contexts (Lacy et al., 2007; Schauer & Schieve, 2006; Walters & Worley, 2006; Walters et al., 2003; Worley et al., 2004a). Other studies show the grades of rural background students are comparable with their urban counterparts (Polasek & Kolcic, 2006). It is anticipated that rural placement experiences can provide students with broad clinical experiences through various conditions, procedures and large numbers of patients (Jones et al., 2003; Kamien, 1996; Worley et al., 2000) and exposure to rural beliefs and values (Murphy et al., 1994).

The reality of the rural context is more multifaceted and complex than the pastoral ideal that is reflected in the rural health education literature.<sup>21</sup> Research shows that some undergraduate students harbour anxiety (Denz-Penhey et al., 2004) and negative attitudes toward rural health education programs (Edwards et al., 2004; Jones et al., 2000; Jones et al., 2003; Jones et al., 2007; Jones et al., 2005; Price et al., 1994; Smith et al., 2001; Zaidi, 1986) but indicate they would go to a rural centre if they had to (Bruening & Maddern, 2003). Like all aspects of life,

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<sup>21</sup> These notions present an aspirational picture of an idealised rurality. Chapters 5, 6 and 7 will show this 'rural idyll' to be an influential discourse that was created and sustained in the practice of rural health education under study in this research.

rural practice has its negative as well as its positive aspects however according to Strasser (1992, p 40) "... from an undergraduates viewpoint the advantages of rural practice are overwhelmed by the disadvantages". These views of rurality may underpin the reluctance of some students to participate in rural health education<sup>22</sup>, as discussed on page 82 of this chapter.

Nominated restraints include family responsibilities (Jones et al., 2007; McDonough et al., 1992), part time employment commitments, accommodation issues (Jones et al., 2007), financial burden (Jones et al., 2007), social dislocation (Jones et al., 2005) and difficulties with transportation (McDonough et al., 1992) and academic disadvantage (Delaney et al., 2002; Hays et al., 2005; McDonough et al., 1992; Sturmberg et al., 2003). Furthermore, it appears that many educationalists and health professionals are harboring negative attitudes toward rural practice (Barney et al., 1998; Birks & Green, 1999; Couper, 2003; Sturmberg et al., 2003). As attitudinal and perceptual barriers are now recognised as the primary factors that discourage graduates from entering rural practice (Wang, 2002; WONCA, 1996), many educationalists are incorporating strategies to deal with these (McDonough et al., 1992; Smith et al., 2001; Zaidi, 1986).

### SECTION 3. SYNTHESIS OF KEY THEMES USING PROFESSIONAL SOCIALISATION THEORIES

In this section, the key themes that emerged from the above literature review are synthesised. Foundational concepts of socialisation theories are used

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<sup>22</sup> The 'rural ordeal' is another influential discourse that emerged from the notion of rural difference in the practice of rural health education in this study. Its underlying meanings and influence on students' identity formation are discussed in chapters 5, 6 and 7.



to theoretically explain a great deal of what is known in rural health education. It is a discussion that usefully highlights the possibilities for new knowledge construction within the field of rural health education.

In Australia, much has been achieved in rural health education over the past decade. A comprehensive infrastructure for supporting rural health education is now in place (McNamara, 2007). Moreover, many schools of nursing, medicine and pharmacy appear to be implementing rural health education in their undergraduate programs. These processes have positioned Australia as a world leader in this area. The strong vision to redress the rural health workforce shortages has resulted in the formation of a set of diverse activities that come together under the collective umbrella of rural health education. These include, attracting rural youth to health careers, amending admission policies, rural health lectures, problem based learning, and experiential rural placements. It is anticipated that the short term outcome of these activities is a stronger rural health workforce, which is expected to improve health outcomes in rural Australia in the long term.

The 1980-90s represents a period of infancy for rural health education. It was an era in which a great deal of energy was expended on establishing a comprehensive infrastructure to support rural health education in health science education. The rural health education literature as a whole reflects this cultural, social and historical era in six ways; a) the scant attention paid to the notion of rural place, b) the ambiguity surrounding the term rural health, c) the

definition of rural health education, d) the study of its outcomes, e) a greater focus on the notion of quantity rather than the quality of rural health education, and f) the privileging of classical experimental models in research. Each of these will now be discussed.

Firstly, within the published literature on rural health education the role of place in health, practice and education has received little attention. While various attempts at defining rurality using established classification systems exist, these are primarily used by researchers for making references to the various settings in which health interventions, practice or educational activities are taking place. Other disciplines, such as geography, social sciences and humanities recognise that characteristics of places extend beyond the geographical and physical environment (Hawe, 1994). In these disciplines place “... is generally a space with something added: social meaning, convention, cultural understandings about role, function and nature and so on” (Harrison & Dourish, 1996, p 3). It is therefore just one of the social constructs in a broad range of social relationships and social processes associated with rural environments.

Rural health researchers emphasise the way many socio-cultural factors impact on the health of rural populations (Haberkorn et al., 2004; Humphreys & Rolley, 1991; Humphreys & Weinand, 1989; Humphreys & Weinard, 1991). Despite this important relationship between place and health, practice and education, the notion of rural place has only recently been tackled in

rural health education. One study examines whether rural place plays a role in the recruitment and retention of doctors (Lian, 2007). Another examines the role of place in the way people understand, talk about and experience health (Thurston & Meadows, 2003b). Without this level of theoretical consideration of the notion of rural place, there is a tendency for rural health education researchers to emphasise the detrimental relationship between rural places and the health of individuals (Thurston & Meadows, 2003a). For example, rural communities are often described as isolated with a lack of privacy and harmful to health and well being (Wakerman & Humphreys, 2002). These accounts of rural health tend to give a narrow view of rural life.

Secondly, there is little theoretical discussion or debate in defining rural health. Researchers (Humphreys, 1998; Wakerman, 2004) have written about the difficulties in defining rural health and raise questions about whether it is a unique area or simply part of a broader national concern for health. These questions are only recently beginning to attract some debate within the rural health education literature (Ramsey & Beesley, 2007; Thurston & Meadows, 2003a). For the most arise from an implicit and confusing emphasis on occupational health versus general health. They argue that rural people typically see their level of productivity and ability to work as key indicators of health, which places the body at the centre and therefore supports the notion of Cartesian dualism<sup>23</sup> (Thurston & Meadows, 2003). Rather than critically

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<sup>23</sup> Cartesian dualism and the union of mind and body are often understood as conceptions that contradict each other. For example, Rene Descartes is well known for his dualist conception while also

interrogating such concepts that often underpin reports of rural health status, rural health education researchers tend to uncritically reproduce statistics as the truth<sup>24</sup> about the health of rural populations.

Thirdly, rural health education has been conceived and defined as a rural health workforce supply strategy. The rural health education literature is replete with descriptive accounts of schools, departments, educational programs (Baillie et al., 2007; Beaton et al., 2001; Chaytors & Spooner, 1998; Commonwealth Department of Health and Aging, 2005; Critchley et al., 2006; Hays, 1990; Hays, 1992; Hays, 2001b; Hays, 2002a; Hays, 2005; Hays et al., 1996; Hays & SenGupta, 2003; Hays et al., 1993; Hays et al., 1994; Hays et al., 2005; Murphy et al., 1994; Norington, 1997; Walters & Worley, 2006; Walters et al., 2003; Worley et al., 2000; Worley et al., 2004c), characteristics of teaching and learning and modes of effective curriculum delivery in rural areas (Baker et al., 2005; Khadra, 2001; Mak & Plant, 2005; Newbury et al., 2005). Collectively this body of literature provides a set of technical dimensions of teaching and learning activities within rural health education. It tends to omit meaningful descriptions of actual curricula content, learning objectives and anticipated outcomes, other than that of workforce recruitment.

recognising the relation between the human mind and body. Several authors have understood this as a contradiction within Cartesian philosophy.

<sup>24</sup> The introductory chapter discusses the notion of truth (pages 353, 483 and 513). It argues that versions of truth are always the effect of specific techniques that emerge from power and knowledge. The way institutions and individuals employ various discursive practices that perpetuate notions of truth about, and through, rural health education is discussed in chapter 3.

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Fourthly, when rural health education is constructed as a rural health workforce strategy, rural workforce recruitment becomes a logical outcome measure (Australian Medical Workforce Advisory Committee, 1998; Committee, 1996.; Humphreys et al., 2002b; Khadra, 2001; Levitt & McEwin, 2002; Mara et al., 1998; Murray & Wronski, 2006; Reid, 2004; Wearne & Wakerman, 2004). Some researchers have slightly deviated from this research practice to measure students' satisfaction with rural learning experiences (Waters et al., 2006; Worley et al., 2004a). Others have examined students academic performance as a measure of the effectiveness of teaching and learning in the rural context (Walters & Worley, 2006; Walters et al., 2003).<sup>25</sup> These studies are the minority in a body of literature that is primarily concerned with measuring rural health workforce recruitment as an outcome of rural health education. Measuring recruitment is challenged by the long time it takes for students to graduate and become established as health professionals. Studies measuring students' intention to take up rural practice acknowledge these claims may not necessarily translate to actual rural practice uptake.

Fifthly, the focus in rural health education is on quantity. Concerns about quantity span the number of:

- health professionals currently working in rural Australia;

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<sup>25</sup> These studies suggest that students who learn in the rural context are academically performing as well as students undertaking more traditional pathways in undergraduate medical education. They also show that while some students are satisfied with their rural learning experiences, others are less interested in studying in a rural area.

- health professionals who have rural backgrounds or undertook rural health studies in their undergraduate courses;
- Rural Clinical Schools or Departments of Rural Health that have been established and how they might be classified;
- Universities including rural health curriculum in their courses;
- students undertaking rural placements;
- students expressing their intention to work rurally after participating in rural health education, and also
- graduates actually taking up rural practice following graduation.

Against these concerns for quantity, the discussion is frequently polarised around arguments about the way the rural health workforce is 'in crisis' (Wearne & Wakerman, 2004). While these are legitimate concerns for the field, they conflict with the way the focus on Australia's health care system tends to centre on issues of how to best provide high quality (Fletcher, 2000). The concept of quality is difficult to define because it is a broad term that has little agreed meaning (Ibrahim et al., 1998 cited in Fletcher, 2000). The Institute of Medicine (Boyce et al. 1997, cited in Fletcher, 2000, p 14) provides a general definition of the quality of health service provision: "... the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". The US Office of Technology Assessment (cited by Fletcher, 2000) adds to this definition, the concept of '[and] reduces the probability of undesired outcomes'.

Similar arguments can be made for the quality of rural health education.<sup>26</sup> There is a need for rural health education to ‘increase the likelihood of its desired outcomes in ways that are consistent with current professional knowledge, which may reduce the probability of undesired outcomes’. Outcomes can refer to learning outcomes and/or rural health workforce recruitment outcomes. One of the critical ways that rural health education can fail to achieve an appropriate level of quality is through insufficient information and/or understanding of its nature and outcomes in nursing, medical and pharmacy education. The way knowledge is generated and understood within the field depends on the research methodologies and methods being used.

Sixthly, the majority of rural health education research has been guided by the positivistic paradigm. All research arises from and authorises itself within a given culture of inquiry (Denzin & Lincoln, 2006). The majority of studies undertaken in rural health education have been generated through classical experimental designs and positivistic paradigms. These have historically been assigned a high degree of legitimacy in medicine. Quantitative methods and methodologies have been traditionally heralded as the gold standard in an era where science and scientific methods are considered to be authoritative (Holmes et al., 2006). Nevertheless, they may have obscured other possibilities for knowing rural health education. In turn, other possibilities for measuring its

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<sup>26</sup> Refer to chapter 7 for a full discussion of the quality of rural health education.

outcomes may have also been veiled. This may be one reason why rural health education tends to be format-driven and outcomes-focused.

The tendency to construct rural health education as a rural health workforce strategy and focus on recruitment as an outcome measure may also be driven by the influence of the Australian government (Australian Medical Workforce Advisory Committee, 1998; Committee, 1996.; Committee of Inquiry into Medical Education and Medical Workforce, 1988; Commonwealth Department of Health and Aged Care, 2001; Productivity Commission, 2005a). Perhaps one of the most important achievements over the past ten years has been raising the Australian government's awareness of the challenges rural communities are facing in terms of access to and accessibility of health services. The Australian government now sponsors many of the initiatives driving rural health education. As Prideaux (2007) indicates, it is external support that carries a set of obligations.<sup>27</sup> The main obligation is to provide evidence that the programmes being sponsored are having the desired impact on the rural health care system—the recruitment of new graduates to rural practice. While such impact or outcome focused research may provide external sponsors with information they need (Prideaux 2007), there are more profitable studies that rural health education can undertake.

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<sup>27</sup> Instead of understanding this as a form of top-down exercise of power, in this thesis power is located outside 'conscious or intentional decision' (McHoul and Grace 1999, p 21). What this means is that while the Australian Commonwealth government may impose boundaries around what rural health education must include (for instance, 25% of medical students with a rural background) in order to qualify for funding, educationalists can re-negotiate these boundaries in curriculum design and implementation. Power, therefore, does not arise from one group controlling another but is instead dispersed. These understandings of power as a form of governmentality were first introduced in the introductory chapter (pages 143 and 473) and will be further developed in chapters 3 and 4.



Rural health education, as a field, is now maturing. In the process of maturation there seems to be a shift in focus from infrastructure, strategies and outcomes to concepts and constructs. Many schools of health science education are now incorporating rural health education in various forms. This implies there has been some definition of a body of knowledge known as rural health. It appears however, that different writers have different ideas about rural health. John Humphreys (1998, p 5) argues it is a notion that conjures up a 'large and mystifying field of activity'. If rural health educationalists and researchers are having difficulty clearly articulating what the foundational concepts and constructs might be in rural health, this challenge will be even greater for educators with no familiarity with rural health.<sup>28</sup> Many of the decisions for including rural health components in undergraduate programs are taking place at the macro level. Some academics working with health science educators may well be charged with rural health education in their teaching portfolios without understanding its problems or issues. These academics may be relying on the cultural deficit representations of rural populations that are in circulation to inform their teaching and learning practices.

The concepts of rural disadvantage and difference (as cultural deficits) are strong and convincing accounts of the rural condition. Within the field of rural health and rural health education they are now accepted as truth (cf. Bourke et al., 2004; Cheers, 1990). These claims of truth need to be critically examined.

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<sup>28</sup> Chapter 5 will provide evidence that some health science academics charged with teaching rural health education are unfamiliar with the rural context. Because of this unfamiliarity, they expressed discomfort assuming responsibility for teaching most of the rural health content in their units.

Drawing on the writings of Foucault (1979) it is possible to question such truth claims. According to Dreyfus & Rabinow (1983), Foucault not only encourages researchers to bracket issues of truth to consider the related issues of meaning by examining their practical conditions of existence. This suggests that rural disadvantage and difference are only one account of the social reality of rural health. In this era of health science education there is a recognised need for a multiplicity of perspectives. There is an urgent need for the generation of evidence and a greater use of established theories to develop models of best practice for rural health education.

In order to improve rural health education curriculum it is important to be able to identify where and to what degree problems might be occurring and what might be working well. Identifying the best practice of rural health education is a difficult task because much of its teaching and learning practices occur in the context of health science education. Rural health education is therefore context dependent (Hays & SenGupta, 2003). Much of what rural health educationalists are trying to achieve relates to raising students' awareness of the problems of rural health and generating their interest in rural practice as positive and viable career option. There is an assumption that these objectives are taken up by academics, rural health practitioners and students in health science education. The degree to which this occurs is difficult to assess because the voices of health science academics, rural health practitioners and students are under-represented in the literature reporting rural health education. It is

therefore difficult to gauge the efficacy of many rural health education models. In-depth descriptions and interpretations of the day-to-day practice of rural health education in action are required. These accounts will be useful for assessing its efficacy as a rural health workforce supply strategy by understanding the context and improving its structural properties as a socialising and identity shaping process. This suggests the theoretical perspectives used in this study must account for the structural perspectives in the study of rural health education, which is taken up in chapters 3 and 4.

In academia, people engage in teaching and learning by making choices about where and how to implement certain knowledge and practices. The incorporation of new content, such as rural health education, is rarely a task performed on demand—it must assimilate with the existing objectives and curriculum content that is valued in health science education. It must also be meaningful to students learning needs. These are both essentially issues of agency that require deeper interrogation because there are few studies that have actually asked students about their *experiences* of rural health education. It appears there is a need for greater reflection upon such matters in the rural health education literature because at present it is not well understood how health science academics or undergraduate students understand, talk about and experience rural health education. These are not issues of form and function, nor are they issues of structure and outcomes. They are issues of rural health education process that relate to human agency, which is a concern developed

further in chapter 3 and accounted for in the research methods outlined in chapter 4.

It seems that questions regarding the meaning of rural health education demand the study of human beings. Since the 1970s education theorists have convincingly argued that education finds its most fundamental meanings in the functions it carries out in the intellectual development of individuals (Moring 1973, 77, 80, 99, 01). Even the earliest philosophers, such as Socrates, argued strongly that the essence of being human emerges in the complex relation between individual, society and groups. Contemporary theorists continue to defend this thesis (Bourdieu, 1990; Bourdieu & Passeron, 1996; Foucault, 1972; Foucault, 1973; Foucault, 1975; Giddens, 1982; Giddens, 1984). This is an argument that is therefore valid for understanding how academics, rural health practitioners and students relate to, and interact with, rural health education. It points to the need for the theoretical perspectives relating to professional socialisation that are used in this study to account for agency as well as structure.

In other disciplines, education is symbiotically considered from the perspective of the relation of the individual with society. These are not unfamiliar concepts in the field of rural health and rural health education. Both Richard Hays (2003) and David Snadden (2006) have placed emphasis on the importance of context in the design of rural health education. Context is also particularly well reflected in Paul Worley's (2002a; 2002b) Integrity Model for examining relationships in rural health education. Explicit

acknowledgement of the relation between individuals and society points to new and exciting directions for rural health education research. It is an acknowledgement that makes it easy to emphasise the transmissive and socialising dimensions of rural health education. These perspectives reinforce the need for a socio-centric orientation in this research, which is reflected in the theories of socialisation and identity outlined in chapter 3.

The work undertaken within the humanities and social sciences has established a long tradition for arguing that which is human should be centralised in matters relating to education. These perspectives make it possible for new questions to be asked in rural health education that introduce complex and interdisciplinary views. Conceptualising rural health education as a socialisation process is a view that has already found expression in the broader health science education research in both positivistic (Taylor et al., 2000) and sociological (Clouder, 2003b; Cohen, 1981) arguments. The next section draws upon some central ideas of socialisation to theoretically explain some findings that are emerging from the rural health education literature.

#### *EXAMINING RURAL HEALTH EDUCATION THROUGH THE LENS OF SOCIALISATION*

The purpose of this section is twofold. It provides a theoretical reading of the rural health education literature to show how the concept of socialisation can be used to theoretically anchor most of the activities that are underway in rural health education. It also centralises the importance of people in the process of

socialisation, which supports the argument that voices present in the literature may be representing rural health education in certain ways to advance particular agendas.<sup>29</sup>

If rural health education is to be learnt, used and modified to attract students to rural practice, it must first be embodied. This requires a process whereby individuals construct knowledge in personally meaningful and relational ways that emerge from their interaction with the social and cultural environment. The relationships between clinicians and patients, health service and university research, government and community, and personal principles and professional principles (Worley, 2002b) are all crucial to the formation of meaning in rural health education. These relationships have been put forward as the 'key to discerning quality' (Worley, 2002a) in education. One reason for this is that knowledge production is not only marked by processes of power, but it also sets the conditions for inclusion and exclusion. Focusing on whose voice is present and absent in the literature not only reveals the contributions to, but also the gaps in, knowledge, which points to the existence of unequal relations of power within the field. Applying the theoretical lens of socialisation to what is known in rural health education is a way of making these relations of power more explicit.

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<sup>29</sup> For instance, the introductory chapter (page 373) showed how rural activists construct rural people, places and practice as different and disadvantaged as a powerful means of attracting scarce resources to the field.

The literature review shows that rural background and lifestyle issues are among the most important factors when considering recruitment of new graduates to a rural area.<sup>30</sup> These findings can be explained using theories of primary socialisation. There are various processes of socialisation that all individuals undergo throughout their lives. In the early stages of life information is passed from more knowledgeable members of society to younger children, which is referred to as 'primary socialisation' (Berger & Luckman, 1966, p 129-137).

Family, education and religion are the social institutions that most strongly influence the 'primary' (Moorhouse, 1992) or 'preparatory socialisation' of young people (Edgar et al., 1993). Primary socialisation is therefore a preparatory process of socialisation that creates personal boundaries. These boundaries are integral for children learning to organise their insight, ideas and ultimately their behaviour (Berger & Luckman, 1966). Personal boundaries are extremely powerful. They act as internal reservoirs from which children generate tacit understandings of the world to organise their behaviour and interpret the actions of others (Berger & Luckman, 1966). The cultural preferences, knowledge, beliefs and values that undergraduate students learned as children powerfully shape the way they view social reality as adults. It makes sense then, if students have acquired cultural knowledge that is unique to rurality, they will have a strong affinity for rural areas.

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<sup>30</sup> Refer to chapter 2, page 1073 for the discussion about the correlation between students rural background and rural intentionality.

The literature shows that some undergraduate health science students may or may not be interested in taking up rural practice as a result of their rural health education experiences (Edwards et al., 2004; Jones et al., 2000; Smith et al., 2001; Zaidi, 1986). Such findings highlight students' active sense of agency through their willingness, or unwillingness, to accept that participation in rural health education is conducive to their knowledge, skill and attitude development. These findings can be explained using theories of secondary socialisation.

As individuals move through life, their personal boundaries are extended through a process of secondary socialisation and they are more likely to engage with all forms of education in a critical and reflexive way. The social knowledge that is acquired in later stages of life generally stems from contexts that extend beyond the immediate boundaries of family (Berger & Luckman, 1966). At this stage of socialisation individuals are less likely to passively receive the beliefs and values of others. They are more aware of the process of knowledge acquisition. This may be why some theorists move away from the term 'secondary socialisation' (Berger & Luckman, 1966), to call this process 'education' (Bohannan, 1963; Kroeber, 1948). It is a vulnerable position for students because their learning experiences, and the meaning they assign to them, are open to the influence of others.<sup>31</sup> Depending on what occurs in the

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<sup>31</sup> In rural health education, these 'others' can include health science academics, rural health practitioners and lay community members. The media and family members are also a strong influence on the way students shape meanings and form their identities. The term 'agents of socialisation' (Kalmus 2006) has been coined to refer to individuals and processes that shape the socialising experiences of individuals. This concept is outlined in more detail in chapters 3 and 4.



socialisation process, rural health education can either be conducive, or counterproductive, to attracting students to rural practice.

Another key dimension that is implicit in the rural health education literature is acknowledgement that health science education is primarily concerned with the production of competent beginning level health professionals. Academics, students and health professionals enter rural health education with understandings of health and medical disciplinary knowledge, lived experiences in a diverse society, and the expectation that students will be involved in learning opportunities that develop them as emerging doctors, nurses and pharmacists. In other words, they draw upon taken for granted institutional and personal values to shape what can and cannot be known and enacted within rural health education.

Professional socialisation is a key component of secondary socialisation (Berger and Luckman, 1966). It is an important life stage in which personal boundaries are once again reshaped. Individuals learn and internalise the values and norms of a particular occupational group (Cant & Higgs, 1992; Jacox, 1973), such as nursing, medicine and pharmacy. Different professions value particular forms of social knowledge that work to order ideas, concepts, and categorisations in particular ways (Hall, 1987). Individuals learn and incorporate these forms of social knowledge into their personal boundaries (Hall, 1987). These become the symbolic resources that students use to shape their own behaviour and sense of

self in ways that are valued in that particular professional context (Carpenter, 1995).

What emerges from this process of reflecting on rural health education using the lens of socialisation is explicit recognition that people are the central actors in rural health education. The literature shows there are several groups of people who shape the socialisation process—health science academics, rural health practitioners, undergraduate health science students and rural people. While some voices are loud and articulate in the rural health education literature others are barely audible or represented by others. The dominant voice of medical researchers shall now be examined with a focus on how they construct particular representations of rurality in rural health education literature.

Rural health education literature draws heavily upon the language of medical researchers. It is a professional and expert language that plays an important role in the process of 'objectification', where rural people are spoken about using concepts of 'health', 'disease', or 'illness'. It is a powerful language that has been effective for improving rural health conditions through arguments for better access to, and accessibility of, health services in rural areas (Humphreys, 2007; Humphreys et al., 2002a; Humphreys et al., 1996; Humphreys & Rolley, 1991; Humphreys & Weinand, 1989). The strength of the medical expert voice is perhaps most visibly represented through the successful arguments that with more resources, and increased accessibility to medical care, a stronger rural health workforce can be achieved (Haberkorn et al.,

2004; Humphreys, 2007; Humphreys et al., 2002a; Humphreys et al., 1996; Humphreys & Rolley, 1991; Humphreys & Weinand, 1989). It is anticipated that a stronger rural health workforce will lead to better health outcomes for rural populations. While this use of language serves a means to a political ends, it has also created, and continues to maintain, the conditions for understanding rural health and rural health education.

The majority of the rural health education literature implies that social conditions of rural health and rural practice are the outcomes of practices of science. Contextual research that focuses on the specific and unique health experiences of rural people and health care needs of rural communities are now available (Humphreys & Weinand, 1989; Humphreys & Weinard, 1991; Panelli, 2001). The majority of rural health education papers, however, tend to cite large national health research (Strong et al., 1998; Titulaer et al., 1997) to make generalised statements about the inequities in health status and health care services between rural and metropolitan Australia. By doing so, health, disease and illness are abstracted from the personal histories of people living in rural areas. These latter research models are based on procedures of objectivity, isolation, identifiable biomedical characteristics and prediction—they are outcomes of science rather than accounts of the social experiences of rural people.

The scientific medical perspective has been described as the 'language of variables' (deZeeuw, 1993) where people and communities become

scientific objects . They are subject to ongoing observation in order to describe, analyse and test patterns of, and relations between, health invariance. This process of observation and objectification has also been described as a 'clinical gaze' (Foucault 1973) in which medical professionals simultaneously organise analytic, diagnostic, empathic, and healing pathways through observational, data-gathering tools in a nonverbal way. Such a prevailing perspective can be interpreted as part of a process of exclusion; other ways of knowing rural people and rural communities are obscured by the medical and scientific perspective.

It appears that expert scientific and medical knowledge is not only a source of authority and legitimacy within the field of rural health, it has also become the epistemic condition for understanding rural health through notions of 'rural pathology and disadvantage'. This appears to have shaped rural health education in two ways. First, rural pathology and disadvantage in terms of health service accessibility indicates the need for a stronger rural health workforce. Consequently, rural health education is currently being shaped and advanced as rural health workforce supply strategy. Second, the epistemic condition for rural pathology and disadvantage has become so ingrained in thoughts and practices within rural health that there are now moves to use these as the foundational constructs and concepts in rural health education. For example, poverty is an integral topic area of many international rural health education programs<sup>32</sup> and the notion of disadvantage is now being put forward

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<sup>32</sup> For instance students and faculty in Hawaii are provided with various readings and the book *Within Our Reach: Breaking the cycle of disadvantage*, which is written specifically for interventions to aid children at risk due to adverse socioeconomic circumstances. Eide (1996) claims this text resonates with the

as a key organising construct in Australia (Bourke et al., 2004; Wilkinson et al., 2001). It seems the constructs of rural pathology and disadvantage have superseded their purpose as tools for politically lobbying and influencing distributional decisions. They are now being used as the organising framework for developing rural health education curriculum.

The nature of teaching and learning reflected through the majority of the publications tends to confine rural health education to an individual activity in the highly situated context of rural health. While there is some variation in the models of rural health education, they predominately involve raising student awareness of the disadvantage rural communities experience accessing health services, knowledge about health status differentials, and exposing them to the realities of clinical and social aspects of rural practice. Rural health education is not an isolated teaching and learning program, but one that is part of broader nursing, medical and pharmacy programs. This suggests the teaching and learning context in which academics, health professionals and students who participate in rural health education is much broader than is implied in the literature. There are no papers discussing the ways rural health education might articulate with the broader undergraduate nursing, pharmacy and medical programs, of which these practices are part. Worley (2002b) reminds us that the

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situations and needs facing rural communities as a whole and claims rural communities can be considered as 'disadvantaged groups'. Furthermore, Yuala Lumpar asserts there is a need for undergraduates to become familiar with the rural health infrastructure to "... understand the social and economic aspects of the rural poor ... the objective of the training is to make students understand the problems faced by the poor in rural areas so that when they practice in rural health areas after graduation, they will understand the problems of rural people" (Yadav 2003, p 94).

integrity and quality of the whole of education depends on the sum of its parts (see chapters 3 and 4 for extended treatment of this argument).

The majority of the literature discusses rural health curricula in a way that extracts rural health education from its context in health science education (lectures, classroom work) and rural health care practice (experiential placements). There has been little consideration of how the assumed goals and objectives of rural health education as a workforce supply strategy might differ or articulate with the goals of health science education or objectives that health professionals may be working toward in this practice.

The voices of health professionals, health science academics and students who are central actors in the teaching and learning practices of rural health education are barely audible in the literature. When they are present, they are often represented through an academics voice, and aspects of their lived experience are reconfigured to fit the conditions of the research being reported. For instance, research measuring students' rural intentionality often involves probing or leading questions, rather than allowing student's accounts to emerge from the data. A significant proportion of the context of health science education or rural health care as it is used in daily practice is missing from rural health education writings. How then can 'rural health education' claim to offer a basis for education about preparing and attracting students to rural practice?

As a whole, literature reporting rural health education initiatives or outcomes appears to overlook the notion of agency in relation to

students. By doing so, it tends to imply that students are receptacles for knowledge rather than active agents in the co-production of knowledge. There is one strand of work within rural health education research, however, that provides important insights about student's active sense of agency. The work of Helen Tolhurst (2006; 2006; 2003; 2004) and Graeme Jones' (2003; 2007; 2005) is important here. Their studies focus on the attributes and knowledge that students bring to rural health education. It is an approach that shifts the focus away from narrowly focusing on how rural health education impacts on students. Acknowledging individuals sense of agency is important because rural health education largely relies on experiential modes for students to learn about rural health and rural practice.

For any educational program to succeed there is a need to develop curriculum that is meaningful and relevant to students, rural health practitioners and academics. Reflecting upon the beliefs and values that students may bring to rural health education provides important knowledge for developing curriculum content that is attractive and conducive to students learning needs, as well as attracting them to rural practice. It is also time to establish similar understandings of the attributes that academics and health professionals bring to the situation of rural health education. Only then will it be possible to develop rural health education curriculum beyond the technical to develop models of best practice.

Increasingly, the rural community is being used as a learning context to empower students in their journey as emerging health professionals and potential future rural health care workers. Rural health education therefore represents a contemporary form of pedagogy that centralises the importance of the rural community as a teaching and learning environment to engage a diverse group of undergraduate students. It is a model that emphasises the experiential nature of teaching and learning and assigns a high degree of authority to knowledge held by health professionals and local people who live and work in rural areas. These non-academic educators may hold very different pedagogical understandings of what rural health education might be to those enshrined and privileged within the bounded terrain of academia. There is little critical attention paid to the ways academics and health practitioners might shape rural health education. As such, these 'partial epistemologies' (Giroux, 1997) have been hidden and the 'plurality of perspectives' (Bauman, 1997) have faded into the background as medical and scientific perspectives dominate rural health education literature.

In order to develop rural health education as a rural workforce supply strategy, there is an urgent need for alternative ways of constructing it. For this to occur, it may be beneficial to conceive rural health education as a process of professional socialisation that shapes students personal and professional identity formation. The suggestion that rural health education might be something other than a rural health workforce supply strategy may be confronting for some



people. However, the process of re-producing dominant constructs of rural health education implies an assimilationist perspective, rather than a critical model. The critical orientation in which this research is located requires some questioning of these established positions.

Alternative readings of the rural health education can be achieved by incorporating the voices of health science academics, health professionals and undergraduate students who are primarily responsible for the socialising practices of teaching and learning. These new voices may reveal what the current rural health education literature does not say. Language and critical theorists claim that in order to say anything there are things which must not be said (Derrida, 1976). These marginal perspectives of rural health education may be crucial for developing best model practices of rural health education.

Without a well developed critical perspective it is difficult to understand the discrete ways in which these different groups contribute to the educational content, processes, and outcomes of rural health education. These insights underscore Worley's (2002a) warning that ignoring relationships, or taking them for granted, is to do so at students' peril. Each of these groups, through their active sense of agency, will invest their own values and beliefs into rural health education. When rural education is theorised in this way—as a contested pedagogical space—to which different groups bring their beliefs, new questions about its workforce outcomes can be asked. What if rural health education is

working against the goal of attracting undergraduate nursing, pharmacy and medical students to rural practice?

The analysis in the chapter has shown that rural health education is primarily constructed by government, researchers and educationalists as a rural health workforce supply strategy. This is merely one of many discourses for understanding rural health education. Ian Parker suggests that,

*“ Discourses do not simply describe the social world, they categorise it, they bring phenomena into sight once an object has been elaborated in a discourse, it is difficult not to refer to it as if it were real Discourses provide frameworks for debating the value of one way of talking about reality over other ways” (Parker, 1992, p 74).*

In the previous chapter, it was argued the field of rural health has searched for epistemologies, or ways of knowing itself, that maximise its professional and cultural standing as a discipline. These moves can be somewhat problematic. Within the field of rural health the rhetoric speaks of improved access to health care services through building a stronger rural health workforce. Until there is a deeper understanding of how rural health education operates at the practice level, there is no way of knowing what this argument turns out to offer. Rural health education may well be meeting its intended aim of instilling in students an interest in a rural career. It may also be at risk of contributing to the marginalisation of rural communities as the broader field of rural health gains power through association with the language used by various groups.

There is a need to understand how the situated and bounded understanding of rural health education as a rural workforce strategy

interacts with other forms of knowledge, beliefs and values in undergraduate health science education. The ways academics, health professionals and students interact during the day to day activities of rural health education, has not yet been considered. The language used by these groups will also work to produce and reproduce meanings, beliefs and values about rural communities. Until deeper theoretical insights are generated about the practice and outcomes of rural health education it is "... open to the attack of being a fad, driven by idealists who are prepared to compromise academic standards for their social agendas" (Worley et al., 2004a, p 207).

Three theoretical perspectives relating to socialisation, professional socialisation and professional identity formation have emerged from this review of the literature. These are taken up, discussed further and used to develop a theoretical framework for this study in the next chapter.

## CHAPTER 3      DESIGNING A CONCEPTUAL AND ANALYTIC FRAMEWORK FOR THE RESEARCH

### INTRODUCTION

In rural health education research, the emphasis of most studies is on descriptions of education models or evaluating the outcome of various teaching experiments. The focus of these studies has largely been on whether students might be committed to rural practice as a viable career option as a result of rural health education. Some studies examine students learning in terms of increased knowledge and skills, and others measure students' acquisition of professional and clinical knowledges. Few consider the meanings students' might be constructing about rural people, or the qualitative personal changes they might undergo. Furthermore, the process by which students become professionals who are competent and willing to take up rural practice has not yet been considered.

The literature review developed the argument that rural health education involves a complex social relation between individuals, society and groups of people. Making this social relation explicit points to the possibility of theorising rural health education as a process of socialisation. This process includes the formation of personal and professional identity as students come to view themselves as emerging members of a profession with the knowledge and responsibilities which may be an indication of rural practice membership.

The conceptual and analytical framework developed that is used to guide the remainder of the research is presented in this chapter. The central

tenets of the research framework and their relationship to the needs identified in the literature and the research methods used in the study are presented in Table 10. The central tenets of the research framework are also discussed at length within four sections in this chapter. Section one draws upon key perspectives from professional socialisation. The framework builds upon Paul Worley's work on the importance of relationships to show how rural health education as a process of professional socialisation can be appropriated by different people in different ways, by different groups, in different contexts. Consequently, in this study rural health education is understood as a process of professional socialisation as interaction that is mediated by relations of power and knowledge.

Section two draws upon identity theories and advances student's personal and professional identity as an outcome of rural health education. These theories come together in a way that is useful for understanding rural health education as a socialisation process that involves indirect and direct professional, cultural and psychosocial contributions from different groups in different social contexts.

Section three presents a new conceptual framework that was used in this research. The conceptual framework uses the notions of pedagogical space and boundaries. It hinges on the dialectical relation between material practices and symbolic meanings that individuals attach to their spatial environment. These are essentially relations between power and discourse that condition the

way rural health education can and cannot be appropriated in different contexts. Thus, it is the interaction between power and discourse that mediates the conditions for meaning making and identity formation in rural health education.

Section four presents the Critical Discourse Analytic framework used in this study. The analytic framework is based on Norman Fairclough's model of critical discourse analysis to study three aspects of rural health education as a process of socialisation. First, how rural health education was constructed by different groups in different contexts. Second, how meanings were produced through teaching and learning. Third, how the process of professional socialisation was influencing the way undergraduate students shaped their personal and professional identities. The following table illustrates the relationships between the main themes to emerge from the literature review and the theoretical perspectives outlined in this chapter and the practical methods used to execute the research (the methods are discussed in chapter 4).

**Table 10101010, Relationships between needs identified in the literature review and the theoretical perspectives and research methods used in this study.**

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Research needs identified in literature review (Chapter 2)	Theoretical Perspectives (Chapter 3)	Research Methods (Chapter 4)
<ul style="list-style-type: none"> <li>Rural health education is mainly constructed as a rural health workforce supply strategy and this may be constraining what we can know about its practice and outcomes. New ways of constructing, and therefore, studying rural health education are required.</li> </ul>	<ul style="list-style-type: none"> <li>Professional socialisation theories offer a new way to construct rural health education. In this study it is understood as a contested pedagogical space in which different individuals and groups construct rural health education in ways that advance particular agendas. These are essentially issues of power and language, which can be accounted for using the critical perspective that is characteristic of more contemporary professional socialisation research.</li> </ul>	<ul style="list-style-type: none"> <li>To capture the way language is used and shaped by power in the socialising process of rural health education four data sources were identified: (a)Published rural health education literature (b) participants experience of rural health education (c) curriculum documents, and (d) participant's accounts of rural health education.</li> </ul>
<ul style="list-style-type: none"> <li>Most rural health education research uses classic research designs that tend to privilege quantitative research methodologies. The majority of research is organised within the medical perspective. Research that uses qualitative methods, which is organised from different health disciplines perspective, and incorporates greater critical analysis is required for studying rural health education.</li> </ul>	<ul style="list-style-type: none"> <li>Professional socialisation is a theoretical perspective that crosses many health disciplines and can be located with a qualitative research framework. More contemporary professional socialisation research tends to be oriented within a critical perspective.</li> <li>Language use and social interaction is a way of examining the human dimension of rural health education. In this study, professional socialisation is theorised as a process of social interaction.</li> </ul>	<ul style="list-style-type: none"> <li>To gather and create the language texts for analysis two main qualitative data collection methods were used: (a) fieldwork (b) semi-structured interviews.</li> </ul>
<ul style="list-style-type: none"> <li>Research tends to focus on the structural aspects of rural health education and gives little attention to the way individuals understand, talk about and experience it.</li> </ul>	<ul style="list-style-type: none"> <li>Rural health education is conceptualised as a contested pedagogical space to which different individuals and groups bring ideological understandings to continually negotiate its</li> </ul>	<ul style="list-style-type: none"> <li>A multi-leveled coding strategy allowed the categories and themes to inductively emerge from the data. It also allowed for a deductive</li> </ul>

<p>New ways of examining rural health education are required to capture individuals' capacity for human agency in a way that also acknowledges structural dimensions.</p>	<p>boundaries for meaning and identity making.</p> <ul style="list-style-type: none"> <li>Theories of space, power, discourse and identity are used to develop an analytic framework for examining language use in rural health education. Focusing on interaction and language used in rural health education allows both structure and agency to be accounted for in a way they does not privilege one or the other. This is because language use and social interaction is always context dependent and therefore influenced by structural conditions.</li> </ul>	<p>analysis of the data to specifically focus on technologies of power and their influence on knowledge.</p> <ul style="list-style-type: none"> <li>A systematic approach to the data analysis was undertaken using the following sequenced steps: (a) becoming familiar with the data (b) identifying themes and examining relationships between discourses (c) identifying discursive strategies deployed by academics, practitioners and students, and (d) examining the effects of discourse.</li> </ul>
<ul style="list-style-type: none"> <li>Most research tends to measure students claims of rural intentionality or rural practice uptake as outcomes of rural health education. These studies are challenged by temporal constraints and difficulties posed by the need to control for independent variables. It is time to give some consideration to alternative outcomes of rural health education that have not yet been considered within the field.</li> </ul>	<ul style="list-style-type: none"> <li>During the process of professional socialisation the social values held by particular groups are transmitted to students through social interaction. Students can choose to adopt, or not to adopt, these new belief and value systems as their own. These processes influence the way students shape their personal and professional identities. Identity has been identified as a key determinant of students career planning. In this study, personal and professional identity is therefore examined as an outcome of rural health education.</li> </ul>	<ul style="list-style-type: none"> <li>In order to analyse meaning and identity formation, a number of critical discourse analytic techniques were purposefully selected from Fairclough's toolkit. These included: (a) assumption,(b) word meaning, (c) intertextuality, (d) transitivity, and (e) modality.</li> </ul>



## SECTION 1. DEVELOPING THE THEORETICAL FRAMEWORK

Section one introduces the notion of socialisation and theorises rural health education as a process of professional socialisation. It draws upon the literature concerning professional socialisation in the health professions and higher education. Some aspects concerning the concept of rural health education as an emerging discipline are briefly tackled. However, the literature concerning professionalisation or the process by which professions are formed is not included. Considerations of the process of professional socialisation that have relevance for this study are summarised at the end of this section. Chapter 2 identified the need for greater consideration to be given to human agency and structure in rural health education research.<sup>33</sup> As such, this section also focuses on the debate surrounding structure and agency within the professional socialisation literature.

### *THE CONCEPT OF (PROFESSIONAL) SOCIALISATION*

In the social sciences, socialisation typically embraces three aspects of a process. First, the transmission of culture from society to individuals (Kalmus, 2006). This perspective derives from the point of view of society and tends to be functionalist in orientation. Second, the means of becoming human in one's social and cultural environment (Kalmus, 2006). This perspective derives from the point of view of the individual and tends to be interpretative in orientation. Third, that socialisation is a process of cultural and social reproduction that has

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<sup>33</sup> Refer to pages ~~373~~ and ~~363~~ for this discussion.

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the potential to sustain relations of power and control according to individual's acts of resistance, negotiation and contestation in the production of meaning and culture. This perspective acknowledges the link between education institutions and wider society and tends to be critical in orientation. There have been many attempts to define and clarify the term 'socialisation'. These definitions reflect the functionalist and interpretative perspectives, which will be briefly discussed to show how they are unsuitable for this study. As the literature review shows a critical perspective was warranted for this study and this perspective will therefore be discussed in the later part of this section.

Within the field of rural health, rural health education appears to be understood as a powerful structural reality through which students can be shaped in ways that will attract them to rural practice. It is an account of education that aligns with the most prevalent approach to the study of socialisation, which is known as functionalism. The functionalist tradition originates from a positivist worldview dating back to Comte, Spencer and Darwin (Slattery, 2003). In sociology, it is a theoretical perspective that understands human interactions as predictable functions and assumes that certain conditions inevitably produce certain effects. If such predictability existed, rural health education could easily achieve its rural health workforce supply objective. By organising certain conditions, such as sending students to rural areas for their clinical practice rotations, students could be attracted to the rural workforce by simply learning about aspects of rural life and practice.

Attracting to rural practice, however, is more complex than simply exposing them to rurality.

The literature review showed the specific role of rural exposure in increasing rural practice uptake is inconclusive.<sup>34</sup> Several studies now report students may or may not take up rural practice as a result of their rural learning experiences (Easterbrook et al., 1999; Orpin & Gabriel, 2005; Zaidi, 1986). These studies powerfully illustrate just how elusive predictability can actually be. Functionalism is one of the oldest theoretical perspectives of sociology and other social sciences. It is characterised by a concern for the status quo, social order, consensus social integration and actuality (Zeichner, 1978; Zeichner, 1980). It approaches these general sociological concerns from a standpoint that tends to be based on the application of the scientific method to the objective social world. These include realist, positivist, and determinist research methods (Burrell & Morgan, 1979, p 107) and education approaches.

Many of the principles that underpin rural health education appear to reflect the functionalist account of socialisation. If we reflect back on the concept of 'rural exposure' it is "... primarily intended to provide awareness of rural medical practice and rural communities" (Ranamuthugala et al., 2007, p 286). In other words, from this process of learning, or socialisation, students are expected to acquire knowledge about rural lifestyle and culture (Ranamuthugala et al., 2007). The expectation that rural exposure will provide students with a

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<sup>34</sup> See page [1063](#) in chapter 2 for this discussion.

favourable attitude towards rural practice is an assumption that social processes are indirect and emerge from being with other people (Lovell, 1980) in the rural context.

There are many aspects of rural exposure that can be understood as a socialisation process in which students can develop favourable or unfavourable attitudes toward rural practice. Socialisation is a complicated process in which individuals learn and can choose to acquire the attitudes, norms, values and ways of thinking held by the members of the group to which they belong (Zanden, 1988). The exchange of socio-cultural knowledge affects individuals in different ways. The acquisition of rural cultural knowledge may cause students to shape their attitudes and behaviour as they learn and internalise new habits, ideas, attitudes, and values of rural social groups. Although rural health education may well be a powerful determining structure, students play an active role in interpreting and making sense of their individual experiences. The important role students' play in their own socialising process highlights the need for the field of rural health education to give consideration to human subjectivity and agency. These concerns for human agency can be found in interpretative accounts of socialisation that will now be considered.

One of the main goals of this research was to consider the socialising effects of rural health education on students' identity formation.<sup>35</sup> Identity formation is contingent on the way students actively and individually construct

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<sup>35</sup> The research aims were presented on page ~~533~~ in the introductory chapter of this thesis.

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meaningful human experiences as they engage in rural health education. Meaning making occurs through an intricate process of interpretation (Denzin & Lincoln, 2006). This suggests that students make sense of the teaching and learning activities in the full context of their everyday experience. The interpretative paradigm of socialisation is useful for understanding student's experiences of rural health education because it acknowledges students agency in their constitution of meaning and identity. While functionalism is concerned with the explanation of human behaviour, the interpretative paradigm is concerned with understanding (Denzin & Lincoln, 2006).

A better understanding of the meaning and identity making possibilities that rural health education presents to students is important for the development of curricula that influences their decisions to work rurally. Interpretative philosophy, with its emphasis on subjectivity, also makes a considerable contribution to socialisation research. Researchers drawing upon interpretative philosophies claim it is not possible to understand knowledge and social entities as objective things

(Denzin and Lincoln, 2006). Instead of the realist ontology<sup>36</sup> held by functionalist researchers, interpretative scholars present a context dependent, subjective and relational view of knowledge, people and social entities. From an interpretative stance meanings are understood to emerge from individuals' subjective

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<sup>36</sup> Realist ontology holds that the world is composed by individual physical objects (which includes human bodies). These objects are considered to be tokens of external mind-independent individuals with identity conditions **Strawson, P.** (1959), *Individuals: An Essay in Descriptive Metaphysics*, London. From this perspective, the identity conditions of physical objects (including the actions of humans) can be explained on the basis of causal properties.

experience. The importance of tacit<sup>37</sup> knowledge is therefore well acknowledged (Polanyi, 1966). These knowledge claims are understood as interpretations (Heidegger, 1962; Merleau-Ponty, 1962) rather than representations of reality. Interpretative perspectives assume a transcendental ontology, which means that people can have different desires, ambitions, values and beliefs. Society and culture is recognised as dynamic entities that have unique histories and particular collective traits and attributes. People are parts of these systems that are ever evolving through social interaction with others.

Interpretativism stresses both the innovative and creative aspects of individual's participation in society and the fact that students both contribute to and are affected by processes of socialisation. Although not research into professional socialisation per se, similar findings have been found by Helen Tolhurst and her colleagues in their studies of medical student's backgrounds and intentions to take up rural practice (Tolhurst, 2006; Tolhurst et al., 2006; Tolhurst & Stewart, 2003). Together these studies suggest that students entering rural health education are by

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<sup>37</sup> Michael Polyani's (1966) thesis argues that the fact that people know more than they can tell in various situations of everyday life bears witness to the existence of 'tacit' knowledge. According to Polyani (1966), tacit powers of the mind are decisive and predominant at all levels of human cognition, not only on the pre-linguistic level, but also in the domain of articulate culture. They represent people's ability to acquire and hold knowledge. He says: "while tacit knowledge can be possessed by itself, explicit knowledge must rely on being tacitly understood and applied. Hence, all knowledge is "*either tacit or rooted in tacit knowledge. A wholly explicit knowledge is unthinkable*" (italics original).

no means a *tabula rasa*<sup>38</sup> upon which some instructional action operates from their surroundings. Socialisation can be understood as a shaping process as though it is a 'unitary and rational process embedded in an understandable culture' (Tierney, 1997). The marker of socialisation, from this perspective, relates to the successful understanding and incorporation of the values, beliefs and knowledge held by the profession.

In this study rural health education is viewed as more complex and problematic than is implied in either the functionalist or interpretative socialisation literature. Neither of these approaches challenges the status quo because they assume a value neutral research stance (Zeichner, 1980). Evidence that rural health education is a successful rural health workforce supply strategy is varied (Ranmuthugala et al., 2007). It would therefore be problematic to assume that by placing students in a rural context they might automatically acquire a sense of affinity for rural practice. Power relationships between people and place differ in these education models. These relations of power therefore appear to play a role in student's experience of, and decisions about, rural practice. This suggested a more critical account of professional socialisation is useful for this study because socialising experiences and identity formation differs between individuals.

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<sup>38</sup> Tabula rasa is a Latin term (meaning scraped tablet or clean slate) coined by Aristotle to refer to the epistemological thesis that human beings are born with no innate mental content but instead build their knowledge gradually from experiences and sensory perceptions of the outside world. It was later picked up and used by the British philosopher John Locke See: Bruner, J. (1985), 'Models of the Learner', Educational Researcher 14, 6, 5-8.

Undergraduate health science education prepares and equips students with the knowledge, skills and attitudes for their future roles as health professionals. This is a process that maintains social order as students are socialised into 'normal' ways of behaving like health professionals. Health science education can therefore be understood as a set of educational activities that condition student's relationship with society. The existence of such processes of socialisation also supported the argument that critical perspective for examining the socialising practices of rural health education was required in this study.<sup>39</sup> Indeed, many contemporary studies of socialisation tend to assume a critical approach by focusing on the relationship between the individual and the power of social control in society (Clouder, 2003a). Steeped in the work of Marxism, Gramsci and the Frankfurt school of thought, the critical paradigm contains sociological theories that seek to explain the nature of creating and maintaining social order. Critical theories also serve as catalysts for the transformation of that order (Hammersley, 1999). Thus, in this study critical perspective was useful for the interpretation of social conditions that appear to sustain the inequality and oppression of rural groups.<sup>40</sup> Rural health education therefore seems to play an important role in conditioning the way students think about rural communities and act as health professionals who may or may not develop an interest in rural practice.

<sup>39</sup> See pages ~~243~~, ~~373~~, ~~693~~ and ~~723~~ for similar arguments for critical perspective in this study.

<sup>40</sup> These arguments are developed and supported with extracts from the data collected in this study in chapters 5 and 6.

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Within the field of rural health it appears the rural workforce agenda is so well accepted within the field that the ideological means for maintaining social order may have been obscured. Because of this, a way of examining the pedagogy of rural health education as a political text was required. It was important to acknowledge that rural health education not only influenced the way students developed as emerging health professionals, but also the way they were being conditioned to think about rural people, places and practice. Using a critical perspective was useful in this study because it made it possible to examine the institutional and societal practices that shape the day-to-day operation of rural health education. These are often influenced by unequal relations of power in society. For instance, rural health education has been framed within a field that privileges a cultural deficit model for understanding rural communities. This is a form of knowledge that can also be understood as power.

It appears that rural health education processes not only play a role in shaping pedagogy, but also in shaping wider society. This is because the relationship between knowledge, power and practice can effectively maintain social order and control (Foucault, 1972; Foucault, 1975; Foucault, 1980). These relations can function as a form of social control that reinforces the status quo in Australian society and perpetuates the ongoing marginalisation of rural communities, which is an argument developed in chapters 5, 6 and 7.

Two main approaches can be identified in the critical paradigm concerning socialisation. One emphasises the reproduction (e.g., Althusser, 1971; Bernstein, 1979; Bourdieu, 1977; Bowles & Gintis, 1976) of dominant cultural assumptions and ideological beliefs. Institutions, structure and individuals are strongly constituted as embedded elements of a general culture and dominant ideologies. That is, no one has to tell academics, practitioners and students to reproduce the cultural deficit ideas that are in circulation about rural communities. Instead, using alternative ways to talk about rural people, places or practice simply does not have the same focus within the field of rural health. Another approach to socialisation in the critical paradigm emphasises production (e.g., Giroux, 1981, 1983; Willis, 1977) where powerful groups actually create cultural assumptions and ideological beliefs. From this perspective, institutions and individuals play a central role in constituting the prevailing ways of understanding the rural condition, such as rural difference and disadvantage.<sup>41</sup>

This study drew upon the recent writings of Zeichner & Gore (1980) who present a view of the critical paradigm that specifically acknowledges production and reproduction, while also acknowledging agency and structure in the socialisation process. These writings were useful for understanding rural health education, as a process of professional socialisation, which involves students in a particular orientation to practice. It is an orientation that views social worlds and

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<sup>41</sup> The language of rural difference and disadvantage that is characteristic of the political lobbying and grassroots activism that exists within the field of rural health is an example of powerful groups producing particular discourses that have shaped the socialising process of rural health education. The reasons why this language use may be a problem in rural health education is discussed on pages [213](#), [423](#), [443](#), [483](#) and [503](#).

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subjectivity as being embedded and embodied in certain discursive conventions. Several commentators (Foucault 1980) have pointed to this parallel between systems of power/knowledge (or discourses) and the constitutive power of language use (Fairclough 1991). Such “discourses-in-practice” (Foucault 1980) inherent in various institutional or cultural sites involve the exercise of power where distinctive forms of social or professional life are articulated. These constructions of reality are portrayed through lived patterns of action, or “regimes” (Foucault 1980) that discipline student’s lives. Here, the term ‘discipline’ is used to refer to the regulatory control of human action. Universities are institutions of control (as are hospitals and prisons) (McHoul & Grace, 1993) that shape individuals thoughts and actions through socialising processes that manifest in everyday patterns of talk.

Extensive research on the process of professional socialisation has been undertaken in many other disciplines and academic fields. There is a paucity of such perspective within the field of rural health education. The abundance of professional socialisation research, in a multitude of disciplines, provides supportive evidence that rural health education can be usefully theorised as a process of professional socialisation. The value of such a perspective is it allows for some examination of the way students may or may not change their values and beliefs as a consequence of their rural health education experiences. These insights may be useful for generating a deeper understanding about the efficacy of rural health education as a rural workforce preparation and supply strategy.

Of particular interest then, are the significant amount of studies of professional socialisation that have been undertaken within the health science disciplines and academic field of higher education. These are presented in the next section.

#### *RESEARCH IN THE FIELD OF HEALTH PROFESSIONAL SOCIALISATION*

To understand socialisation in rural health education, it is important to first understand the socialisation of health professionals. What follows is a brief overview of some professional socialisation studies that have been undertaken within the disciplines of medicine, nursing and pharmacy, and within the academic field of higher education. These studies are useful for illustrating how the concept of professional socialisation has evolved over time. The more contemporary perspectives on professional socialisation, which are oriented within the critical perspective and focus on the role language plays in the process, provided useful theoretical insights for this study.

There are two seminal studies of the professional socialisation of medical students that have had a profound impact on the way research has been traditionally conducted in this area. The first study, reported by Merton, Reader & Kendall (Merton et al., 1957, p 41), of medical students found that students "... learn a professional role by combining both its component knowledge and skills, attitudes, and values and to be motivated and able to perform this role in a professionally and socially acceptable fashion". Professional socialisation, according to Merton et al (1957) is a process of induction where education and

professional training has its own normative subculture that transmits its codified values to students.

Throughout the 1980s theorists began to argue that multiple social contexts, rather than the singular professional context, may play a role in the cognitive as well as affective dimensions of socialisation (Cohen, 1981). These arguments were theoretically significant to this study because they confirmed the need to consider the normative aspects<sup>42</sup> of student's broader curricula. This suggested the need for this study to provide some description of the different social processes through which students are socialised into their vocational fields. In other words, it was necessary to examine rural health education in its broader context of undergraduate health science education as well as students experiences of rural exposure. Such a perspective departs from the typical way in which rural health education tends to be examined and reported independent of the broader health science education programs. These concerns are taken up further in the study procedures, which are discussed in the next chapter.

The second study, reported by Becker et al (1961) examined the development of professional attitudes as a function of medical students' reaction to situational factors during their educational experiences. Professional socialisation, according to Becker et al (1961) is a process in which students react to medical school. These classic studies of professional socialisation suggest the

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<sup>42</sup> Normative aspects of health science education and rural health education are discussed on pages ~~653~~, ~~723~~ and ~~1573~~.

attitudes most likely held by future graduates may be formed and developed before entering training programs (Luke, 2003).

Throughout the 1980s and early 1990s most studies of professional socialisation in higher education were framed within modernist perspective. In one study Bragg defined socialisation as the process "... that allows education to achieve its goals of transmitting knowledge, skills, the values and attitudes and habits, and modes of thought of the society to which they belong" (1976, p 3). This position was echoed by Weidman who emphasised socialisation to be a process by which "... persons acquire the knowledge, skills and dispositions that make them more or less effective members of their society " (Weidman, 1989a, p 292). Dunn's (1994) work reflects similar sentiments, with the statement that socialisation is "...the process by which individuals acquire the attitudes, beliefs, values and skills needed to participate effectively in organised social life". These instrumental positions underpinned Tierney's (1988) early studies of organisational culture and Kirk & Todd-Mancillas (1991) study of 'turning points' in a graduate students life.

The early literature on professional socialisation describes how the professional socialisation process characteristically triggers some form of transformation in student attitudes, identity and/or behaviour. Most studies use Merton's (1957) functionalist ideas about socialisation that individuals acquire and internalise an understanding of culture. More recently, professional socialisation theorists draw attention to the way "... culture is

approached as the sum of activities in a profession or organisation and socialisation is the process through which individuals acquire and incorporate those activities" (Tierney, 1997, p 4). These interpretative perspectives are critical of the way culture has been approached as a relatively constant and stable entity that can be understood through reason (Tierney, 1997). Such accounts of culture also reflect the anthropological notions of cultural relativism. From this perspective, all cultures are considered to be of equal value, but are just different, which suggests the need to study culture from a neutral point of view. According to Tierney (1997, p 5) only when culture is constructed as stable and coherent is it possible for researchers to develop the argument that individuals are able to learn and acquire that culture.

A great deal of the rural health education literature can be located within these culturally relativist modes of understanding culture. There is an expectation that by 'exposing' students to rural experiences they will 'acquire' knowledge about rural place and rural practice through a series of planned educational activities. The rural placement is a good example of this. Implicit in these activities is the socialisation process through which students are expected to learn the norms and values or the 'realities of rural practice' (Eley et al., 2007) in order to develop a sense of affinity with rural place.

The difficulty with such accounts of socialisation is they endorse a "... rational view of the world in which reality is fixed and understandable, culture is discovered, and the individual holds an immutable identity that

awaits ... imprinting" (Tierney, 1997, p 5). Clouder (2003) draws attention to the 'reactive' (Merton et al., 1957) way in which students respond to medical culture and suggests that individuals develop 'ways of acting' (Becker et al., 1961) that avoid conflict. These findings are illustrative of the capacity of individual agency within the powerful structures (Clouder, 2003). Accordingly, students may only be partially moulded by the socialisation process (Clouder, 2003b). As a rural health workforce strategy, rural health education may therefore require more meaningful curriculum development than simply exposing students to rural experiences. An indepth understanding of the socialising practices and influences of rural health education can be achieved through talking and observing academics, rural health practitioners and students who are engaged in such teaching and learning activities.<sup>43</sup>

Throughout the 1990s and early 2000s studies of professional socialisation began to explicitly acknowledge individuals active sense of agency. In their study of nursing students Fitzpatrick, While & Roberts (Fitzpatrick et al., 1996) reported students most valued educational experiences that relate to practice as they envisioned it. Similarly, Secrest et al (2003) examined what individuals felt when they became engaged in professional socialisation upon entering nursing and reported themes of belonging, knowing and affirmation. As Clouder (2003) reports however, for the most part studies of professional socialisation in the

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<sup>43</sup> These arguments have direct relevance to the data collection procedures used in this study. These are described in full in the next chapter.



health science disciplines tend to assume a largely deterministic position<sup>44</sup> (Dalton, 2004; DuToit, 1995; Melia, 1987; Moorhouse, 1992). This has led some researchers to argue students may actively seek to be socialised because they have chosen a particular profession. On the basis of this premise, it is often argued that students have already chosen to adopt certain professional values and transform aspects of their sense of self (Lurie, 1981; Wentworth, 1980). It is more likely that most professional socialisation researchers have not incorporated sufficient critical perspective in their work (Clouder 2003).

The more contemporary perspectives of professional socialisation tend to challenge the deterministic accounts of professional, social and organisational culture. Elevating the notion of 'culture' to the point of representing the sum of knowledge and practices of a group, community, profession or organisation assumes a 'totalising' effect (Tierney, 1997). Such totalisation obscures a sense of consciousness of alterity. For instance, as Boland (1995, in Tierney 1997, p 5) suggests deterministic accounts of professional socialisation obscure the "... contradictions, ambiguities and opposites, and is a means for generating power and control". Nevertheless, being in an unbounded and indefinite social context also demands that individuals must make some sense of the way they have been shaped by cultural processes (Tierney, 1997). In other words, culture is always contested and there are multiple possibilities for individuals to inscribe and reinscribe it with different interpretations and possibilities (Tierney, 1997). These

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<sup>44</sup> Determinism proposes that all events, even human thoughts and actions, are causally determined by an unbroken series of occurrences.

accounts of professional socialisation are more relevant for theorising rural health education because they take into account the heterogeneous nature of rural culture and rural practice.

Cultures, professional, organisational and social, are in a constant state of change and are being continually recreated. Consequently, contemporary perspectives of socialisation mean that it may no longer be possible to assume that rural beliefs, values and norms can be passively transmitted to students through experience and exposure alone. Questions must also be raised, however, about the value of imposing representations of rural culture on students that have been constructed within the cultural deficit model. Rural health education involves students in these cultural aspects of rurality, whether they are imagined or real.

Contemporary perspectives of professional socialisation suggest these experiences engage students, academics and health professionals in an 'interpretative' process. It is a process in which individuals are actively engaged in the act of meaning making (Light, 1980). As Tierney (1997, p 14) suggests professional socialisation is an '...interpretative process involved in the creation—rather than the transmittal of meaning'. Rural health education therefore involves give-and-take where each of these groups make sense of rural health, rural people, and rural practice through their own unique backgrounds and the current contexts in which they reside. Describing and interpreting these

socialising processes was a way of providing rural health education with new ways of understanding rural practice and rural people.

The next section theorises rural health education as a process of socialisation. It places particular emphasis on the role of social interaction in this process.

#### *UNDERSTANDING RURAL HEALTH EDUCATION AS A PROCESS OF SOCIALISATION-AS-INTERACTION*

Social interaction is a key dimension of professional socialisation in all health education contexts, including rural health. Paul Worley's work on relationships is extended in this section by placing his arguments within the theoretical framework of professional socialisation. Using the theoretical dimension of professional socialisation to understand the importance of relationships in rural health education serves two purposes. First, it served a practical function in the research, which was to theoretically guide the description and interpretation of teaching and learning practices in rural health education. The argument developed in this section focuses on the important role social interaction plays in the professional socialisation process. Second, by theorising professional socialisation as a process of social interaction it was possible to account for the dualities of structure and agency in a way that did not privilege one or the other.

Approaching professional socialisation as 'interaction' is currently being advanced as a way of dealing with the society/individual dichotomy

that has challenged this field of research. Such consideration is necessary in this post modern era that acknowledges the multiple realities and highly complex nature of the social world (Sarup, 1993). It is a perspective that foregrounds the notion that professional socialisation may be as much problematic, as automatic. This essentially points to the dialectics of individual's experience within wider socioeconomic and political structures. As such this section considers the dialectical processes that may occur in rural health education as a process of socialisation. It is a discussion that requires some explication of the notion of power and the role it might play during interaction throughout the professional socialisation of students during their rural health education experiences.

Socialisation can no longer be viewed from a purely structural or agency perspective<sup>45</sup>, therefore, it may be useful to view it as a dialectical process. It is an interactive process that takes place between two sets of actors – those being socialised, and the agents of socialisation (Kalmus, 2006). A dialectical view of socialisation is espoused by several social theorists (Berger & Luckman, 1966; Giddens, 1984; Tierney, 1997). Rather than considering the process as a linear one, this perspective approaches professional socialisation as a dialectical process (Kalmus, 2006). It is a perspective that "...embraces the individuals being socialised, the agents of socialisation, and the dominant systems of society" (Kalmus, 2006, p 226). These arguments are theoretically significant to the way rural health education was understood in this research. Conceptualising rural

<sup>45</sup> See pages [313](#), [1233](#), [1283](#), [1343](#) and [1373](#), for further discussion about the importance of acknowledging students agency in rural health education.

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health education as an interactive and dialectical process, involving context specific actors, pointed to the need to account for the different ways rural health education may be appropriated by different agents (practitioners and academics) of socialisation in different contexts (university and rural health care agencies). These concerns are taken up further in the overview of research methods used in this study, which is presented in chapter 4.

When professional socialisation is theorised as interaction it involves four components that are mutually influential relationships. According to Kalmus (2006) these include a) the transmission of culture to individuals (structure), b) the process of becoming human in ones environment (agency), c) the interactive process between two sets of actors—the individuals being socialised (agency) and socialising individuals (agents), and d) the field of socialisation (context). In rural health education these relationships are particularly well described in Paul Worley’s writings about the importance of relationships in rural health education, which his ‘Integrity Model’<sup>46</sup> provides a useful diagrammatic representation (Figure 2).

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<sup>46</sup> Paul Worley’s Integrity Model was first discussed on page 1653 of the introductory chapter.

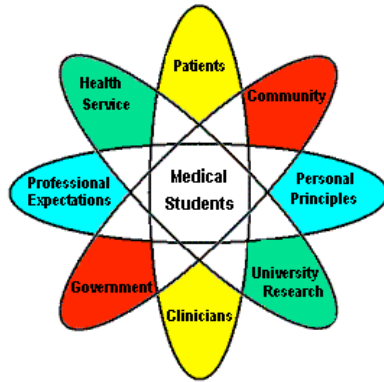


Figure 2222, The (adapted) Integrity Model (reproduced with permission from (Worley, 2002b)

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Paul Worley’s model builds upon the work of Daniel Federman and David Kaufman who both use educational theories to emphasise the importance of human relationships in medical education. From Worley’s model, it can be seen that students are placed at the centre of rural health education. In this central position students must act as brokers as they directly and indirectly interact with various individuals—from educators to health professionals. These relationships take place within, and are influenced by different institutional and social contexts—from the university to the rural community to the health care agencies to the government. There are a number of ways this model was useful for theorising rural health education as a process of professional socialisation and identity formation in this study.

At the most fundamental level Worley’s Integrity Model prioritises people rather than the structure of rural health education or the infrastructure necessary for supporting rural health education. At a theoretical level, when

students are placed at the centre of rural health education they can be seen as individuals who are being socialised. In this central position, students must act as brokers, which foreground their individual agency. From the model it can also be seen that agency, however, is not a concept that can only be confined to students. By acknowledging the relationships between several groups, the notion of agency is also extended to rural health practitioners, academics, and rural community members. Some commentators (Kalmus 2006), refer to such groups as ‘agents of socialisation’<sup>47</sup>. The ability to differentiate between socialising agents (academics and practitioners) and those being socialised (students) was useful for making visible the way socialising agents designate their ability to influence the professional development as students.

When rural health education is theorised as a process of socialisation that is interactive and dialectical, the possibilities for considering two main aspects of socialisation can be realised. These include the individual and society. At the macro level of society, socialisation works as a set of institutional practices, which are predominately discursive that are guided by the beliefs and values of the society, organisation, institution to which a particular socialising agent belongs (Kalmus, 2006). This dimension of socialisation can be examined by analysing the way rural health education is constructed in the academic and rural practice settings. At the micro level of the individual, socialisation relates to the day-to-day practices of social interaction between individuals being socialised

<sup>47</sup> See pages [573](#), [583](#), [643](#), [653](#), [743](#), [1353](#) and [1643](#) for further discussion about agents of socialisation in rural health education.

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(undergraduate nursing, medical and pharmacy students) and the socialising agents (academics, health professionals and bureaucrats).

During their participation in rural health education undergraduate nursing, medical and pharmacy students learn competencies, skills, values and professional standards that are needed to fulfil a professional role in their chosen vocation. As well, rural health education seeks to develop in students some sense of affinity with rural place and rural practice. Merton et al (1957, p 278) defines professional socialisation as "... the process by which people selectively acquire the values and attitudes, the interests, skills and knowledge – in short, the culture – current in groups of which they are, or seek to become, a member". It includes the formation of an individual professional identity, the students coming to view themselves as members of a profession with the knowledge and responsibilities which is an indication of membership. This suggests the construction of professional identity is an outcome of students being in a dialectical relationship with people they encounter in rural health education situations. The study of undergraduate nursing, medical and pharmacy student's personal and professional construction during rural health education was therefore an immediate and effective way to assess the efficacy of rural health education as a rural health workforce supply strategy.

## *SECTION 2: IDENTITY AS AN OUTCOME OF PROFESSIONAL SOCIALISATION*

In this section, the concept of identity is introduced as a new way of



examining the immediate outcomes of rural health education as a rural workforce supply strategy. Identity has been a much maligned concept in the social sciences because it can encapsulate a diversity of definitions and just as many differences. Like professional socialisation, conceptions of identity formation differ across disciplines and according to different theoretical perspectives. One way of framing the debate is to organise the different theoretical positions, using the dualities of structure and agency (Elliott, 2001). Four different theoretical perspectives of identity formation are briefly considered before outlining a dialectical account of identity work that is used to guide this study.

### **Psychosocial theories of identity**

Efforts to attract students to rural practice through rural health education can also be understood using psychosocial theories of identity. One of the seminal papers in the field of rural health education shows the extent to which rural workforce recruitment is contingent on students' identity. In 1977, Cooper convincingly argued there are three types of students. First, those who are committed to rural practice. Second, those who are committed to urban practice. Third, those who are unsure and their career decisions can be influenced by rural learning experiences. The first and second groups can be understood as arguments about individual's core, or personal, identity. Core identity is best explained using psychosocial theories of identity.

One of the earliest theories of identity development is the work of Erikson (1959/1980), which identifies eight stages of psychosocial development (Chickering & Reisser, 1993). Each of these stages relates to age and proceed from issues of trust and development in early childhood to a concern for others besides oneself in later life. It is a theoretical perspective that emphasises individual aspects of identity formation. At the same time, it acknowledges the socio-cultural influences of relationships to the external world on this process. Identity, according to Erikson (1959/1980, p 109) "... connotes both a persistent sameness within oneself (selfsameness) and a persistent sharing of some kind of essential character with others" (Erikson, 1959/1980, p 109). The persistent inner sameness, or the core of one's personal value and belief set, remains a relatively stable aspect of their identity. Spiritual beliefs are one example of one's core personal values and identity. Others aspects of identity, such as sense of belonging, are less stable and constantly being reformed.

Students who identify as wanting to live in rural or urban areas may have developed personal identities that have some affinity with rural place.<sup>48</sup> Research shows that rural background students are more likely to work rurally (Azer et al., 2001; Bushy & Leipert, 2005; Carline et al., 1980; Craig et al., 1993; Fry & Terry, 1995; Laven et al., 2002; Masatoshi et al., 2005; Owen et al., 2007; Playford et al., 2006; Rabinowitz et al., 1999a; Rabinowitz et al., 1999b; Rourke et al., 2005; Smith et al., 2001; Travernier et al., 2003; Ward et al., 2004; Woloshuk et al., 2005;

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<sup>48</sup> The notion of rural place is used here, not as a reference to a geographical locations, but as a space that is characterised by particular cultural belief and value systems. Notions of rural place are discussed in more detail on page [1153](#).

Woloshuk & Tarrant, 2002; Woloshuk & Tarrant, 2004; Wood, 1998) . Other students, who may not have this level of rural affinity and who are unsure of their preferences to work in a particular geographic location, may still be open to renegotiating the boundaries of their identity. For some students, identity relating to their sense of belonging to a particular place is continually being constructed as they make sense of social experiences. It is a process in which the way others perceives one and the way one perceives their own sense of self are united through a process of self reflection. It is this process of reflecting upon experiences that may be conducive for rural health education achieving its goal of influencing student's decision to work rurally as health professionals.

Rural health education is not simply a set of educational activities that raise students' awareness of rural health issues. It includes practical learning experiences that immerse students in clinical and non-clinical aspects of rural place. Rural health education is therefore an opportunity for students to renegotiate their identities. One psychosocial framework for studying the concept of identity developed by Marcia (1966) uses the principles of crisis and commitment.

The principle of crisis refers to those periods of decision-making in which all possibilities are considered and tested as new ways of being are imagined (Marcia, 1966). Other commentators (Davis & Harre, 1990; Ibarra, 1999; Markus & Nurius, 1986) term this process as 'experimenting with possible selves'. The principle of commitment refers to the point at which one makes a

decision about sense of self and consequently reshapes the boundaries of self definition (Marcia, 1966). Another theorist that extends Erikson’s identity theory is Berzonsky (1990) whose work diverts from individuals holding commitments to exploring identity alternatives. The notion of identity styles is used by Berzonsky (1990) to describe the social-cognitive strategies individuals use to face identity issues. It is a theory that involves individuals actively seeking out, elaborating, and evaluating relevant information in order to shape self in accordance with the normative expectations held by significant others. These theories share elements of constructionist theories of identity, which are discussed next.

**Constructionist theories of identity**

Rural health is a social construction. Because this study was interested in the meanings which individuals assigned to their experiences as they renegotiated their identity, the epistemological position known as constructionism (Crotty 1998) was adopted<sup>49</sup>. As an interdisciplinary paradigm, social constructionism emerged from a crisis in the social sciences in the late 20th century (Gergen, 1999). The crisis being the failure of modernist values for reaching some understandings of the social world in which we reside and interact.

<sup>49</sup> Within the field of rural health, rural health education is predominately understood as a rural health workforce supply strategy. The introductory chapter discusses how such ‘truths’ have been uncritically accepted for some time (see pages 353, 483, 513 and 1163). It introduces the argument that truth is just one version of a number of possibilities for understanding rural health education because these meanings are socially constructed.

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One of the aims of this study<sup>50</sup> was to interpret the way students construct their interpretations of rural people, places and practice. This was necessary to order to examine how these constructions influence the way students shape their identities. A constructionist account of meaning and identity formation acknowledges that meaning and identity are continually being formulated. It is a perspective that allows for new interpretations and constructions to emerge over time (Guba & Lincoln 1994). It was therefore necessary to acknowledge the study was being undertaken at a particular time and in a particular location. The possibility that being engaged with the research may have also influenced the way individuals constructed meaning and identity also has to be acknowledged (Guba & Lincoln, 1994). Indeed, it is possible that even before the completion of this study the way the study participants understand rurality and their identities may have changed.

Just as individuals constructions of rurality and identity formation may change over time, so too may their claims about rural practice intentionality. A key point of contention within the constructionist field is the suspicion accorded to modernist assumptions of selves as rational agents, who are free to make choices and act in and on the world (Gergen, 1999). It raises critical questions about the notion of individual consciousness as a reliable account of this world, which in turn situates language as a problematic and political vehicle of representation (Gergen, 1999). Within this paradigm, language is viewed as constitutive (Berger & Luckman, 1966) and the ideas we operationalise in day-to-

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<sup>50</sup> The aims of this study are outlined on page 533 of the introductory chapter.

day interaction are only made possible by language (Burr, 1995; Sapir, 1947). Language, therefore, emerges as a contested 'site of struggle, conflict and potential personal and social change' (Burr, 1995, p 44). Consequently, self is linguistic and relational (Gergen, 1999) and has many possible versions as individuals try and make sense of the social world and their position in it. The accounts of students identity, or descriptions of students rural practice intentionality, provided in this study are therefore moments in time that are likely to change as social circumstances change.

The social constructionist approach to identity rejects any category that centralises the notion of core features as the unique attribute of a social group's members. The theories of Thomas, Berger, Goffman, Becker, and others share the argument that every collective becomes a social object—an entity crafted, reshaped, and operationalised in accordance with reigning cultural rules and centres of power. Students identity, or sense of self, can be understood as an accomplishment that emerges from social interaction: their identity is continually renegotiated in language and relationships (Berger & Luckman, 1966; Gergen, 1999). These insights reaffirmed the importance of examining how language was used by various groups in rural health education because of the significant role it plays in student's identity formation. The way this concern is addressed in the research methods is discussed in the next chapter.

The way language is used in rural health education was recognised as more than a medium for the communication of beliefs and values in

the process of socialisation. Constructionist studies of identity often examine in detail agents of socialisation, the institutions, popular culture and the media. While such studies are oriented in a diversity of intellectual traditions, they share a concern for examining the ways in which socialisation agents organise and project taken for granted beliefs, values and norms that individuals use to shape their sense of self. These theoretical accounts suggest the construction of 'I' and 'other' is of importance in this study. As Shotter (1989) contends the formation of other in language (through social relationships) can inform another's being. Thus, the narratives that 'I' tell about 'you' can shape your identity (Shotter 1989). These theoretical perspectives of identity are closely aligned with anthropological and cultural perspectives, which are discussed next.

### **Socio-cultural theories of identity**

The values and norms that students will choose, or not choose to, internalise as their own are inextricably related to their experiences in the rural context. Some rural health education commentators (Hays & SenGupta, 2003; Snadden, 2006) emphasise the importance of social context in pedagogical design. Socio-cultural perspectives of identity formation also foreground the influence of social context. From this perspective, identity is always understood as being recreated and contested. It is a paradigm that flows from the seminal work of Vygotsky and Bhatkin. As argued by Lev Vygotsky, human development is socio-culturally assisted as individuals appropriate diverse elements of cultural and intellectual life that produces a fusion between sense of

self and a line of cultural development (Vygotsky, 1997) . It is a perspective that once again points to the importance of examining language use in rural health education.

As argued in the earlier sections of this chapter, language plays a key role in the communication of contextual values and beliefs and also in the way individuals construct meanings and identity. One particular area of interest for Vygotsky (1997) is the notion of controlling behavior through signs and symbols. He argues that words are tools, and social interaction is the context in which individuals are exposed to cultural forms, and eventually come to use them in some form or another. In other words, language and sign systems are resources in action, which are inextricably related to thinking as mediated action (Vygotsky, 1997). From the point of view of Bhatkin (1981), sense of self emerges from social activity, dialogue and reflects different positions from which meaning is constructed. Within the socio-cultural paradigm, identity is conceived as an expressible relation to others, which is always dialogical. It is from this perspective that Bhatkin (1981) insists that in the making of meaning, individuals author the world and ourselves through language.

In this research, student identity was understood as a social and historical product of dialogue and social interaction—it is always in a constant state of change as individuals continually negotiate and renegotiate the boundaries of their sense of self. Stuart Hall (1998:22) argues identity is a permanent and incomplete process of reconstruction: "perhaps instead of thinking of



identity as an already accomplished fact, which the new cultural practices then represent, we should think, instead, of identity as 'a production' which is never complete, always in process, and always constituted within, not outside, representation complete". Similar claims can be attributed to those theorists working within the post-structuralist movement where '... the individual subject is viewed largely as an effect of discourse, a product or construct of the ambiguous and unstable nature of language' (Elliott, 2001, p. 11). Madan Sarup (1996:11) argues "... identity is a construction, a consequence of a process of interaction between people, institutions and practices". These accounts of identity represent a shift from the traditional deterministic view of structure, which rejects the role of agency in identity formation. Foucault's later writing tends to take into account the capacity for individual agency (Hall, 2000; Sarup, 1996). For the most part, however, poststructuralist accounts of identity reject single, unified theories of the self (Ward, 1997) in preference of those where the self is 'flexible, fractured, fragmented, decentred and brittle' (Elliott, 2001, p 2). These theoretical accounts of identity added more weight to the need for this research to deal with the influences of structure and agency in student identity formation.

### **Dialectic theories of identity**

Like socialisation, identity theorists are also concerned with the theoretical division between structure and agency that are in existence. The concept of social identity is suggested as one way of bridging this distinction

(Jenkins, 1996). From this perspective, individual identity and the collective shared identity are both understood as being produced and changed by similar, internal and external, social processes (Jenkins, 1996). These dialectic theories of identity are briefly discussed in this section.

Regardless of theoretical orientation, most accounts of individual identity hold that a sense of self is embodied and therefore cannot be meaningful in isolation of the social world of others. Social and collective identity theorists make references to the way individuals and collectives are distinguished in their social relation with others (Jenkins, 1996; Tajfel, 1978; Tajfel & Turner, 1986). For instance, Tajfel (1978, p 61) realised thirty years ago that "... we live in a world in which the processes of unification and diversification proceed apace, both of them faster than ever before" (Tajfel, 1978). It was a consciousness that raised critical questions about notions of identity, group membership and representation that infiltrate the day-to-day interactions in modern societies. Social changes brought about by processes of urbanisation, globalisation, and technologies are significantly impacting upon social identities and collective representations. Over time there have been shifts in the way rural identity has been constructed. Rural farmers were once constructed as the life blood of Australia, who were strong, resilient, down to earth and hard working men. More recent constructions of rural farmers tend to construct rural men as a down trodden, struggling and vulnerable population who are susceptible to depression and suicide.

In this study, identity was understood as the product of a negotiated process. Richard Jenkins (1996) states that social identity is the product of agreement and disagreement, and is therefore always negotiable. Identity is an ongoing process that is 'worked' in interaction and institutionally. It is therefore an ongoing process of defining and negotiating meaning. These accounts of identity embody the notion of change, negotiation and renegotiation of identity in relation to social changes and hegemonic cultural elements. These opposing and conferring theories on identity lent some insights into this study of the identity making possibilities that are made available to students who engage in the socialising process of rural health education.

The theoretical model that constitutes the main subject within this study is a way incorporating analytical attributes of the concept of identity while not ignoring contemporary perspectives. From the theoretical perspectives of identity that have just been outlined, it was clear this study ought to take into account the pressures that continuous social change brings upon individuals as sociocultural entities. It was also necessary to acknowledge students' active agency as modern social actors in shaping their personal and professional identity. In this study, identity was understood as relating to sense of self, based on individual's choice in a process of self reflection. These are important considerations for the field of rural health education because the way students' shape their personal and professional identities has direct relevance to their future career choices.

The link between identity and career planning has already been well established in the other disciplines (Humlum et al., 2007). For instance, Ryynanen (2001) argues the formation of a physician's professional identity and conception of him/herself as a doctor is often taken for granted and considered a by-product of learning. During the process of professional socialisation, undergraduate students learn and internalise not only the knowledge, skills, attitudes, of medicine but also the ethical and moral values of their discipline or profession (Humlum et al., 2007). Of the many learning experiences that students will pass through some will trigger an active construction of professional identity.

Professional identity is a form of social identity. It emerges through social interaction between and among individuals in the professional setting. Social identity relates to the ways people compare and differentiate themselves from other professional groups (Tajfel & Turner, 1989). As individuals gain greater degrees of insight into professional practices and internalise the beliefs and norms of the professional group to which they are seeking membership (Schein 1978) their professional identity gradually emerges. It can be described as the attitudes, values, knowledge, beliefs and skills that are shared within a professional group. These specifically relate to the intellectual internalisation of the values, attitudes and beliefs of the professional the individual is preparing for (Richardson 1999, p 463).

The following section develops a theoretically informed conceptual

framework for examining the process of rural health education as professional socialisation and site of identity formation.

### *SECTION 3. DESIGNING A THEORETICALLY INFORMED CONCEPTUAL FRAMEWORK*

Apart from the field of rural health education, there is a growing body of literature concerning health professional socialisation, but studies specifically concerning the development of identity are less common. This study aimed to describe how academics, practitioners and students understand rural health education in different contexts, and interpret how they produce and make sense of different social meanings<sup>51</sup>. It also considered how students' identities were shaped by these relations. In order to do this, it was necessary to consider how these construction processes might be conceptualised for analysis.

The aim of this section is to develop a new conceptual framework that hinges on the dialectical relation between material practices and symbolic meanings that individuals attach to their spatial environment. Drawing on Paul Worley's (2002a; 2002b) writings about relationships, four conceptual themes were used to theorise rural health education as a process of professional socialisation and identity formation. The conceptual themes included, space, boundaries, relationships, and change, which are reflected in Figure 3. This figure illustrates the complex system of flexible, elastic, embracing, including and

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<sup>51</sup> The study aims are presented on page 533 of the introductory chapter.

excluding boundaries for meaning and identity construction that exist in rural health education.

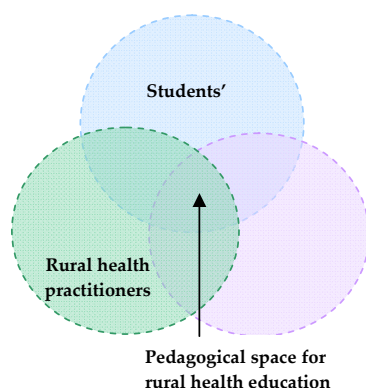


Figure 3333. Individuals and groups shaping the boundaries of the pedagogical space for rural health education

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A key finding to emerge from the professional socialisation literature is that people acquire their meaning and significance only within a context of social relations between people<sup>52</sup>. The rural health education literature appears to suggest that four main groups make contributions to rural health education knowledge through practices in three interrelated social contexts. Undergraduate nursing, medical and pharmacy students are socialised by rural health practitioners, rural people and health science academics. Rural health education, as a process of socialisation, predominately takes places in the institutional settings of the university and rural health care agencies, as well as the social setting of the rural community. The boundaries of these separate, yet

<sup>52</sup> See pages 193 and 363 for arguments about the importance of context in rural health education and the links between place, meaning and identity.

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intertwined, fields of knowledge and practice converge. The Venn diagram, Figure 3, is useful for representing the overlapping boundaries that are created by the relationships between the social, institutional and psychosocial dimensions of rural health education. As a result of these intersecting boundaries a metaphoric space is created—a pedagogical space<sup>53</sup>, which has flexible boundaries for knowledge, meaning and identity formation.

When considering the practice of rural health education, it is also important to recognise that its purpose and nature changes according to the group defining its boundaries. Education is a defining feature of social life just as social relations are a defining feature of the pedagogical space for rural health education. Relations between people always occur somewhere: in a place, a location and at a particular time. No description of the social circumstances of rural health education can be complete without some consideration of their spatial component.

The pedagogical space for rural health education is being continually reconfigured as its boundaries are negotiated, defined and produced through social interaction and local contestations between academics, practitioners and students. Each of these groups will bring their own ideological beliefs and values to the situation of teaching and learning. Rural health education therefore derives from the socially constructed networks of knowledge and action by academics, practitioners and students that cross the boundaries of space. Creating the

<sup>53</sup> The concept of the pedagogical space was introduced on page 153, 223, 533 and 543 of the introductory chapter.

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pedagogical space for rural health education therefore requires a reconfiguration of knowledge in and across spatial, symbolic and geographic dimensions.

The pedagogical space for rural health education is an integral component of structure and agency. The social organisation of this space and the organisation of individuals have become two sides of single preoccupation. Spatial configuration in rural health education lies at the intersection of knowledge, power and practice. Authority is assembled by establishing control over spheres of sociocultural activity, such as teaching and learning, in part through the production of the pedagogical space. In other words, the socially constructed pedagogical space has flexible boundaries that define the possibilities for meaning- and identity making. For these reasons, a full understanding of the actions of academics, practitioners and students in rural health education required some recognition of the spatial nature of structure and human agency<sup>54</sup>. The seminal work of Foucault was used to account for the reflexive relationship between space and social action through his concepts of space, power and discourse.

The pedagogical space is a dynamic space that is shaped by professional, cultural and psychosocial knowledge from different communities. It is a socially

<sup>54</sup> The need for this study to account for structure and human agency in the study of rural health education has been identified elsewhere (see pages [313](#), [1233](#), [1283](#), [1343](#) and [1373](#)). Theories of professional socialisation and identity formation underscored the need to develop a theoretically informed conceptual framework for this study to account for these dual considerations (see page [1433](#) in this chapter). The remainder of this section outlines how the pedagogical space for rural health education was conceptualised in a way that clarifies the influences of intersecting relations of power, discourse and identity. Section four will outline the analytic framework used to analyse these abstract and often hidden dimensions of rural health education.

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constructed metaphoric space in which social knowledge and practices are defined, interpreted, and negotiated by various groups and individuals. This is known as boundary work. Boundary work can be understood as the 'composite set of claims, activities and institutional structures that define and protect particular knowledge practices', (Klein, 1996). At the core of this agenda, is a sense of active agency as a complex spatial dynamic. By focusing on this dialectical interplay, the pedagogical space for rural health education becomes an object of political struggle. It is a political struggle that is enacted in the real life spaces of university classrooms, rural health care agencies and the rural community itself. Foucault theorises space in two ways that were particularly relevant for examining these abstract dimensions of rural health education.

First, rural health education involves students in both intra and extra mural teaching and learning spaces where power relations manifest to influence social action. Foucault uses the term 'heterotopias' to describe the way spaces, such as hospital wards, classrooms, and pharmacies, etc. work to define human existence through relations of power within institutions (Rabinow 1991). These are real spaces in which several incompatible sites are juxtaposed. They remove individuals from everyday social spaces and involve them in spaces that are governed by their own internal social order.

Foucault (1988a) generalises two types of heterotopia: crisis and deviance. Boarding schools and military school are examples of heterotopias of crisis, and prisons and clinics are heterotopias of deviance. In this study, the

classroom, the doctor's surgery, the pharmacy, the district hospital and the rural community are the spaces of key interest. In rural health education these spaces come together as a site of juxtaposition in which there is contest and struggle where different spaces come into contact with other spaces that seem to bear no relation to them (Danaher & Schirato 2000). Each of the groups located within these spaces will define the boundaries of the pedagogical space for rural health education in ways that are contextually meaningful for them.

Second, rural health education generally involves students in a set of power relations that define what is accepted as the way things are done in a particular space. These accepted ways of thinking, talking and acting are not designed as such by those in positions of authority, but are instead inscribed in a multitude of minor, seemingly unimportant activities. Foucault (1977a, pp. 195 ff.) uses the panopticon as a metaphor for the ways in which architectural space is designed to allow surveillance and the exertion of disciplinary power over individuals. The panopticon was a design for Jeremy Bentham's prison in which each cell was visible from a central guard tower. The unique design feature of the tower was that while the prisoners were always observable they could not tell whether or not they were being watched. As a result of this surveillance individuals often effectively disciplined themselves (Foucault 1977).

The technologies of the Panopticon are applied in a less articulated for in higher education. In rural health education, students' are under the constant surveillance of health science academics and/or rural health

practitioners. Not only do the classrooms and rural health care agencies become key learning spaces, they become centres for observing and organising students. In higher education, students are regarded as individuals who need to be supervised, trained and disciplined. Here, the technology of discipline links the production of useful individuals with the production of 'controlled and efficient populations' (Dreyfus & Rabinow, 1983). Rural health education is a process of professional socialisation that imposes its own standards for thought and action. Foucault (1975) calls any process that organises constructs of normality and abnormality, 'normalisation'. An essential component of technologies of normalisation is that they are an integral part of the systematic creation, classification and control of anomalies (Dreyfus & Rabinow, 1983).

In rural health education, the concept of normalisation effectively transforms from a theoretical construct to a technical problem. Political technologies tend to take political problems and recast them using neutral language (Dreyfus & Rabinow, 1983). For example, in Australian society disciplinary power<sup>55</sup> is shaping researchers and social commentators' thoughts and actions through the notion of improving rural health. Here, the ideals of being healthy and living in an urban location are normalised. Rural populations, when compared to their urban counterparts, fall into the category of abnormal because of their failure to achieve the same level of health status as 'normal' urban populations. Language of health is benign. Thus, when interventions that

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<sup>55</sup> Disciplinary power was introduced on p 683.

are designed to improve rural health fail, this only justifies the need for further political intervention. Similar patterns of normalisation are in existence in higher education, however, because they are so taken-for-granted it is difficult to easily recognise their influence and effects.

Undergraduate students are under the ongoing surveillance of academics and practitioners as they traverse their journey in becoming qualified health professionals. Surveillance is a particularly strong form of power because it can proceed in a way that can influence actions without the need for coercion or force. Instead, it involves just a gaze. An inspecting gaze, which each individual under its weight will end by internalising to the point that s/he is his or her own overseer (Foucault 1980, p 155). According to Foucault (1977, p 104), disciplinary power is exercised when individuals monitor themselves and regulate their actions in order to conform to conventional social practices.

These themes of space and human behaviour are germane to the analysis of rural health education as a socialisation process because they move beyond spaces of enclosure and confinement to a new openness characterised by learning in health care agencies and in the rural community setting itself. While this openness makes the boundary of the pedagogical space for rural health education elastic and highly permeable it does not mean the heterotropic spaces disappear or that social control through disciplinary power diminishes. On the contrary, the pedagogical space becomes even more contested because the opportunities for knowledge multiply, divide and overlap with one

another. Rural health education therefore reconfigures spatial interrelationships by collapsing the dichotomy between the public and the private spaces between 'school', 'home' and 'work'. As a process of professional socialisation, rural health education can therefore be seen as a "laboratory of power" (Foucault 1977, 204) that 'links knowledge, power and space' (Herbert 1996, p 49). From this perspective, what can be known in the pedagogical space of rural health education is not only bound to the institutional and cultural spaces of rural health education but is relational to way students have already come to understand their social world.

The pedagogical space for rural health education is metaphoric space in which discourse clearly plays a central role. The term discourse<sup>56</sup> is highly contentious. As a noun it refers to a "... way of signifying experience from a particular perspective" (Fairclough, 1993, p.138). For Foucault (1970, p 138), a discourse is a body of thought, writing or speech that is united by having a set of common terms, ideas or rules. Discourse facilitates social order because it is a way of *"... constituting knowledge, together with the social practices, forms of subjectivity and power relations, which inhere in such knowledges and relations between them"* (Weedon, 1987, p 108) . The findings chapters (5 and 6) will show that while rural health education is understood as a rural workforce supply strategy within the field of rural health, there were other ways it was known by health

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<sup>56</sup> The notion of discourse and its relevance to the study of rural health education is discussed on pages ~~143, 483, and 553~~.

science academics and rural health practitioners in this study. These chapters powerfully illustrate the way that discourse manifests in language use.

Language use and social interaction is a core feature of rural health education. Patterns of language use are historically specific, socially situated, signifying communication practices set within social institutions and action contexts (Weedon 1987). Language, then, is a structure *and* a social practice that changes the nature of rural health education. This change occurs *each* time academics, health professionals and students engage in social interaction *every* time they participate in it. Different discourses are different ways of representation, which tend to be associated with different positions (Fairclough, 2000, p 170). There are many possibilities *and* limits of language for shaping the boundaries of the pedagogical space for rural health education. As such, many meaning making opportunities are available through the teaching and learning practices of rural health education. Focussing on language use was therefore useful for examining the way different groups produced meanings through the professional socialisation process of rural health education, in this study. Language was therefore a useful unit of analysis that provided a critical lens for assessing the way different spatial and discursive contexts shaped rural health education as a socialising and identity forming process.

This study was concerned with more than how various groups construct meanings about rural communities. It was also interested in examining how various discourses influence the way students construct their personal

and professional identities. Discourses are more than ways of thinking and producing meaning. They constitute the 'nature' of the body, unconscious and conscious mind and emotional life of the subjects they seek to govern (Weedon, 1987, p 108). In other words, they condition the ways identity can be formed in rural health education. The pedagogical space was a useful conceptual tool for developing the analytical framework in a way that would be conducive to analysing students' identity formation.

The pedagogical space for rural health education is conceived as a contested site in which undergraduate nursing, pharmacy and medical students shape themselves to become whatever different institutional or cultural spaces hold as desirable. The findings chapters show that within the pedagogical space of rural health education particular systems of meaning (discourses) provided students with information about whom and what they should desire to become. There were two forms this process took.

Firstly, the students were susceptible to the attention of academics and rural health practitioners who often demanded they enact particular attributes that are considered to be characteristic of emerging health professionals. This was often explicit, but most an implicit and unspoken expectation. Foucault understood this form of surveillance as the 'gaze' of the expert upon the body to be subjected (Foucault, 1975).

Secondly, the students came to identify with a particular version of who they wanted to be as emerging health professionals. Foucault

understood this form of desire as 'self governance' (Foucault, 1988b). For any individual the expectation to conform to particular ways of being and the desire to behave in a particular way co-exists in a complex mix, in any space and at any time. These theories are premised on the idea that the internalisation of social and cultural rules is a significant medium of identification (McHoul & Grace, 1993).

The framework developed for this study enabled rural health education to be theorised as a pedagogical space in which students may or may not internalise beliefs and values that have been conditioned by discourses to shape their identity. In order to explicate this argument further it is necessary to give some more consideration to how processes of identification operate. A key finding to emerge from the identity literature is the dual process of identification and classification. Some commentators (Jenkins 1996) claim people, through social interaction, place others within social categories that relate to their interpretations of ways of life, values and attitudes. Internalisation is therefore not the only significant medium of identification.

The shared understandings of contextual codes and social practices that various individuals bring to the pedagogical space for rural health education can be understood as 'normative mechanisms' (Foucault, 1972; Foucault, 1975; Foucault, 1980; Jenkins, 1996). These normative mechanisms work to highlight the boundaries between 'us' and 'them' (Jenkins, 1996; Lamont & Molnar, 2002), which are symbolic boundaries that signify the point where group



similarities and differences begin and end. Students' talk about similarities and differences in their experience of rural health education was therefore an important source for analysing their boundaries of personal and professional identity formation.<sup>57</sup> The analysis of these boundaries was at once an analysis of student's identity formation.

The next section draws on the theoretical framework to develop an analytical model for examining the relations between power, discourse and identity formation involved in the socialisation process of rural health education.

#### SECTION 4. THE CRITICAL DISCOURSE ANALYTIC FRAMEWORK

The purpose of this section is to present the analytic framework that was used for the study. The analytic framework is based on the notion of a pedagogical space for rural health education. This space is understood as having a contested and dynamic boundary that is defined according to the beliefs and values held by different groups in the various institutional and cultural spaces<sup>58</sup> of rural health education. Each view espouses a different understanding of the positioning of academics, health professionals, students and learning, and of the relationship between learning objectives and the practice of teaching. These are issues of boundaries and pedagogical space, and also knowledge (discourse) and

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<sup>57</sup> These theoretical insights about identity formation informed the way data were analysed, which is discussed further in section 2 of chapter 4.

<sup>58</sup> These spaces were discussed on page [1863](#) of this chapter.

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power. The theoretical perspectives underpinning critical discourse analysis (CDA) were useful for analysing the way individuals drew upon prevailing discourses to construct the boundaries of the pedagogical space for rural health education. As these boundaries also delineate what does and does not count as knowledge within the pedagogical space for rural health education, CDA was also useful for analysing the knowledge and identity making possibilities within that pedagogical space.

What follows is a general overview of the principles of CDA as they relate to this study of rural health education, an outline of the Fairclough's CDA research approaches, and some justification of CDA as an appropriate methodology for this study.

In order to study the social circumstances of rural health education it was necessary to give some consideration to their spatial components. The previous section showed spatial configuration in rural health education lies at the intersection of knowledge, power, practice and identity. Norman Fairclough (1989, 1992) proposes a model of critical discourse analysis that is useful for identifying power relations on the basis of texts. Here, text is defined as language in use (Halliday & Hasan, 1985). In other words, any instance of written or spoken language that has coherence and coded meaning in the everyday practice of rural health education was understood as text. This understanding underpinned the decision to use the published literature as a source of data<sup>59</sup>.

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<sup>59</sup> See page 65 in chapter two for the justification for using published rural health education literature as a data source.

When these publications are understood as text that codifies meanings of rural difference and disadvantage (rural deficit) the value of using Fairclough's model as an analytic framework can be realised. The CDA model was particularly useful for isolating processes, both explicit and hidden, in rural health education that may be producing and reproducing social disadvantage<sup>60</sup>. By making these processes in rural health education it may be possible to work towards one of CDA's central goals, which is to lead to significant social changes (Fairclough 2003).

Critical discourse analysis takes a particular interest in the relation between language and power; claiming that cultural and economic dimensions are significant in the creation and maintenance of power relations. This is why Foucault's model of discourse analysis is considered to be a form of critical discourse analysis. Indeed, Foucault's writings form theoretical basis of Fairclough's critical discourse analysis model (Fairclough 2003). Critical discourse analysis privileges the empirical analysis of interactional processes, therefore, lends itself to a study of the concrete and situated nature of language use in rural health education. There are five main principles of critical discourse analysis that made it a particularly relevant analytical model for examining the socialising process of rural health education focussing on interaction, meaning making and identity formation.

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<sup>60</sup> These arguments are drawn from the data analysis undertaken in this study, which are presented in chapters 5 and 6, and discussed in chapter 7.

First, in this study rural health education was theorised as a process of professional socialisation whereby the boundaries of the pedagogical space, and thereby its meaning and identity making possibilities, are shaped in social interaction. So far, the previous sections have argued that discourse plays a strong role in this process. The underlying premise of critical discourse analysis is the experience of individuals as social subjects and their ideas about the social world emerge from their engagements in social interaction (Fairclough 2003). Knowledge, beliefs and values about rurality are therefore constructed by individuals as an effect of what is said during these events. It is also shaped by what academics, health professionals and students accept as taken-for-granted knowledge that shapes legitimate thinking and actions in the various social and institutional contexts rural health education involves them in (university spaces, rural health care agency spaces and rural community spaces). In other words, from the perspective of critical discourse analysis all material practices and symbolic meanings are *ideologically invested* (Fairclough, 1992, p 67). While academics, practitioners and students have learned some common meanings and may take these for granted as common sense, they all support the power of particular social groups.

Second, rural health education has been conceived as one of the key strategies for improving social conditions for rural people through developing a stronger rural health workforce. There is a need, however, to assess the efficacy of rural health education as a rural health workforce strategy. Critical discourse

analysis is designed to assist researchers to address social problems. In addition to focusing on language and language use, CDA emphasises the importance of analysing the linguistic characteristics of social and cultural processes—such as those shaping the socialising process of rural health education. It follows a critical approach to social problems through its purpose of making explicit power relationships, which are often obscure and hidden. Thus, one of the primary goals of critical discourse analysis is making these power relations explicit to achieve results that have practical relevance to social, political and cultural contexts. As such, it provided a useful analytical framework for explaining how social relations of power are exercised by various groups and negotiated in and through discourse (Fairclough & Wodak, 1997).

Third, professional socialisation is a process by which individuals take on the beliefs, values and ideas of the culture or group of which they are part. Rural health appears to be currently understood through a cultural deficit model that constructs rural people as different and disadvantaged. Rural health education, understood as a process of professional socialisation, seems to be reproducing these discourses through social interaction.<sup>61</sup> A key principle of critical discourse analysis is that discourse constitutes society and culture (Fairclough & Wodak, 1997). This suggests that critical discourse analysis is useful for analysing the ways academics, health professionals and students use of language in rural health education might work to produce, reproduce or transform the way rural

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<sup>61</sup> These arguments are based on the data analysis undertaken in this study, which are presented in chapters 5 and 6, and discussed in chapter 7.

people are currently constructed within deficit understandings. As well as being constitutive of society, discourse also produces and reproduces ideology (Fairclough & Wodak, 1997). The deficit model, which holds that particular groups are diminished in varied capacities, is a longstanding, powerful ideology that has been critical to the development and workings of western political systems. The deficit model of rural health is not an incorrect idea; it is the product of political lobbying for the purposes of more equitable resource distribution. Nevertheless, if reproduced as the social reality of rural populations it may produce unjust effects in rural health education.

Fourth, the boundaries of the pedagogical space for rural health education continually changes as different groups negotiate and renegotiate it, according to the social context in which they are operating. At present there is little consideration given to the different ways in which different groups—from students to educators to governments—act to shape the educational content, processes, and outcomes of rural health education. Each of these groups acts on their beliefs to create the meaning and identity-forming teaching and learning experiences for students.

When rural education is theorised as a contested site to which different groups bring their beliefs, but also as a key place where professional identity is developed, the need to examine how ideologies are reproduced in day-to-day language use is realised. Critical discourse analysis emphasises the need to move beyond descriptive accounts of ideology to consider how they are

created and sustained. According to Fairclough & Wodak (1997) critical discourse analysis should incorporate some analysis of how constructions are interpreted, received and their social effects. It was therefore necessary to consider the situated and historical context of rural health education and a central tenet of critical discourse analysis is that discourses can only be understood if they are considered in their historical context (Fairclough & Wodak, 1997).

Fifth, for students participating in rural health education agents of socialisation<sup>62</sup> can have a direct or indirect influence on the meaning and identity making possibilities in teaching and learning. Agents of socialisation that directly influence what is spoken about in rural health education include academics, practitioners, and rural people. At the same time, there are many other agents of socialisation that indirectly influence social interaction in rural health education, such as bureaucrats, politicians, media, family and friends. An important principle in critical discourse analysis is to continually make connections between socio-cultural structures and processes and the more immediate concrete practices and meanings that may be presented in day-to-day actions (Fairclough & Wodak, 1997). Like the contemporary debates taking place within the professional socialisation and identity literature, critical discourse analysis does not consider these structural relationships to be deterministic—rather it espouses the idea of mediation (Fairclough & Wodak, 1997). In other words, it acknowledges the dual dimensions of structure and agency, which were key concerns in this study.

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<sup>62</sup> Agents of socialisation are discussed on page 51.

There were three lines of inquiry that emerged from theorising rural health education as a contested site in which rural culture is internalised and students shape their professional identities. These were formulated as three questions to guide the research inquiry. First, how does the boundary of the pedagogical space for rural health education change according to whose view is being represented? Second, what are the conditions that maintain these boundaries? And thirdly, what are the consequences of these boundaries in terms of new identity formations and new language practices?

Critical discourse analysis provided useful theoretical perspectives for considering how language enacts social and cultural perspectives and identities in rural health education. In two key texts, *Language and Power* (1989, 2001) and *Critical Discourse Analysis* (1995a) Norman Fairclough outlines a three-dimensional framework for studying discourse. It is a framework useful for studies "... where the aim is to map three separate forms of analysis onto one another: analysis of (spoken or written) language texts, analysis of discourse practice (processes of text production, distribution and consumption) and analysis of discursive events as instances of sociocultural practice" (Fairclough, 1995a, p 2). Thus, while analysing language is a central feature of critical discourse analysis it is not the only activity.

For Fairclough (1995; 2003, 10) there are three central components that need to be considered when looking at a text—description, interpretation and explanation. These are:



- the context in which the text is produced;
- the way it is received, and
- the details of the text itself (Smith, 2007).

The language properties of texts are described (text analysis), the relationship between the productive and interpretative processes of discursive practice and the texts is interpreted. Finally, the relationship between discursive practice and social practice is explained (Fairclough, 1995a). According to Fairclough the term text refers to "... the written or spoken language produced in a discursive event" (Fairclough, 1995a, p 135). A discursive event is an "...instance of language use, analysed as text, discursive practice, social practice" (Fairclough, 1995a. p 135). The term discursive practice refers to various ways that individuals actively produce social realities (Davis & Harre, 1990). The term social practice refers to the relatively stable forms of social activity, such as classroom teaching (Chouliaraki & Fairclough, 1999). A discursive event therefore simultaneously refers to text, discursive practice (production and interpretation of the text), and social practice (including situational, institutional and societal practice).

These dimensions of Fairclough's critical discourse analysis model were used to analyse the concrete instances of language that academics, practitioners and students used to shape the boundaries of the pedagogical space for rural health education. These instances of language and language use (texts) were

linked to the various ways that individuals produce meanings about rural people and identity making opportunities for students to either take up or resist (discursive practices).

Fairclough (1992) sees discursive practices as being inseparable from the stable forms of activity that shape rural health education, such as rural health workforce policy, understandings of curriculum structures and teaching and learning practices. According to Fairclough (2001, p 1) "... the reason for centring the concept of social practice is that it allows an oscillation between the perspective of social structure and the perspective of social action and agency". These concerns have been consistently highlighted and are core concerns in this study. Thus, in critical discourse analysis there are three interwoven levels of analysis whereby Fairclough (1995) attempts to establish a systematic method for exploring the relationship between text and its social context. The dimensions on which the method is based are diagrammatically represented in Figure 4.

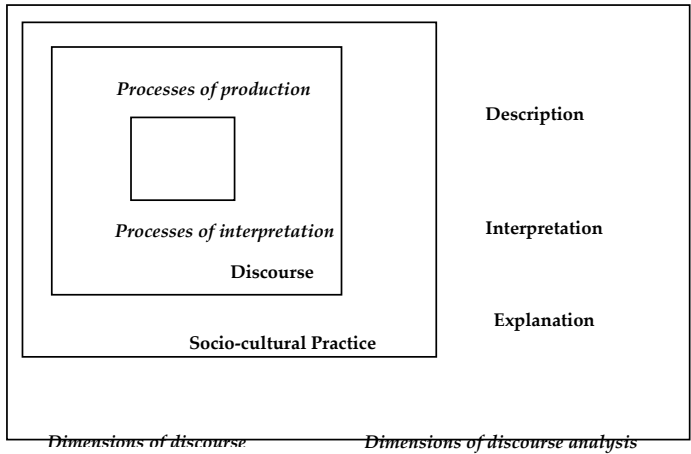


Figure 4444, Three-dimensional conception of discourse and discourse analysis  
(Reproduced from Fairclough 1992)

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The analytical framework described by Fairclough (1995) shaped this research in two main ways. First, it allowed for a multi-layered analysis that incorporated some analysis of how the boundaries of the pedagogical space for rural health education were shaped in different ways by different groups in different contexts (textual analysis). The production of this text relied on a detailed description of the day-to-day practice of rural health education.<sup>63</sup> Second, it allowed for analysis of the ways meanings and opportunities for identity construction were mediated by discourses in operation in different institutional and social contexts and how they are received and interpreted by students. Third, it allowed for analysis of the ways discourses, in circulation in broader society, may have been influencing the socialising process of rural health education.

The critical discourse analysis model developed by Fairclough is a complex, detailed and diverse perspective. It was particularly useful for the analysis of the relationships between the language used by academics, practitioners and students in rural health education, and the various social contexts in which this interaction occurred. Critical discourse analysis begins with an assumption that language plays a primary role in the creation of meaning and identity. It holds

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<sup>63</sup> See page 187 for further details about the notion of thick description.

then that language use must be studied in social context, especially if we are interested in these politics of meaning (Apple, 1996).

The next chapter provides more details about how the theoretical perspectives and the conceptual and analytical frameworks were translated into practical methods and study procedures.

## CHAPTER 4 RESEARCH DESIGN AND METHODS

### INTRODUCTION

The previous chapter demonstrated the theoretical intent of this study and met the key study aim to establish a conceptual and analytic framework for the contextual study of rural health education practices in operation. Such work is meaningless if the practical processes of data collection and analysis are not made visible. The intention of this chapter is to combine the theoretical intent with the practical methods of data collection and analysis in a process that demonstrates how rigour and reflexivity were sustained. It is therefore a fundamental chapter to the thesis, as it details how the research was carried out.

The practical methods and techniques of capturing and analysing the day-to-day teaching and learning practices, as academics, practitioners and students engage with each other in the pedagogical space, of rural health education are outlined and justified. The chapter is presented in three stages that reflect the temporal and pragmatic progression of study. It shows how the diverse components of the study came together as a whole. An exploratory research design and qualitative framework is used to uncover deep data and generate contextual descriptions of the operational detail of rural health education. The research framework combined the analytic framework<sup>64</sup>, techniques of fieldwork and several analytic techniques of critical discourse

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<sup>64</sup> The analytic framework is outlined on page 117 of chapter 3.

analysis (CDA). The way these different elements of study were combined is discussed. This research framework was used to examine wider educational processes that influenced the way meaning and identity was shaped in the pedagogical space for rural health education.

#### *STAGE 1: PLANNING THE STUDY*

Language use and social interaction is a core feature of rural health education. In this study, it was understood as a structure and a social practice. Focussing on the way language was used in rural health education was central to three primary concerns in planning this investigation of the process of socialisation and identity formation. These concerns included:

- organising the sampling procedures to recruit specific individuals to participate in the study
- organising how and where to examine the day to day features of rural health education in operation, and
- giving attention to ethical considerations and standards of morality in terms of what was right and wrong in the study.

In this section, the data sources, sampling procedures, ethical procedures and the negotiated nature of gaining access to the sites of rural health education practice are presented and discussed.

#### **Data sources and sampling procedures**

In this study, it was a complex amalgamation of various decisions relating to people, events and settings. It did not simply represent the targeting and recruitment of participants. A sampling strategy was developed to search for sources of rich information (Patton, 1990). To plan for the study, the settings and participants that had the greatest potential for yielding rich data were identified. Within each of these categories a list of items was established. These items were determined on their potential to most usefully represent data and as such, provided clear parameters for organising data collection. There were four data sources, which included;

- Published rural health education literature (Data source 1)
- The Field (2 data sources)
  - Participants experience of rural health education (Data source 2)
  - Curriculum documents (Data source 3)
- Participant's accounts of rural health education (Data source 4)

Each of these data sources will now be discussed.

***Data Source 1. Published rural health education literature***

The first data source, which formed the basis of chapter 2<sup>65</sup>, was the rural health education literature. Although it is claimed that rural health education requires a stronger evidence base (Ranmuthugala et al., 2007), there is no denying that the published literature has produced a solid body of knowledge. Published literature has been likened to "... a vast kingdom of wisdom built up by those who had ventured before me" (Latham 2004). Through wandering in the "... uncertainty of others' tellings" (Latham 2001), one is alerted to the many circumstantial effects which reportedly influence the success of rural health education. Authors are therefore not simply detached and obscure writers within the field of rural health education. They are active producers and reproduces of knowledge, truth and discourse. Long after their papers have been published these authors remain as active participants in the research of others.

The published rural health education literature provide a range of theoretical lenses that position readers. Bakhtin (1981) reminds us that wisdom only becomes our own when we can give it its own expressive intention. Authors are therefore informants who guide and shape the research of others. In this study, the published rural health education literature was recognised as a rich and powerful data source for identifying how knowledge, discourse and truth is produced and reproduced. The analysis of the rural health education literature was conducted in chapter 2 and synthesised with additional conceptual and analytical theories in chapter 3.

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<sup>65</sup> Using the published rural health education literature as a source of data was first introduced on page ~~803~~ of chapter 2.



### *Data Source 2. The Field: Participants experience of rural health education*

Relations between people always occur in a particular place and at a particular time therefore in order to describe the social circumstances of rural health education it was necessary give some consideration to their spatial component<sup>66</sup>. The academic context and the rural community setting were identified as crucial spaces for data collection.

University classrooms were recognised as the spaces where academics and students participate in lectures, tutorials and interaction about rural health and rural people. These instances of social interaction were considered to be major events in terms of the construction of meanings about rural people and identity making opportunities for students. It was not, however, practically possible to observe each of these sessions, across three disciplines, and across two different campuses at each end of the state and at times that often overlapped. While these activities were not studied directly it was possible to access a great deal of information about these activities through examining curriculum documents (see below for an overview of the curriculum documents used as data sources).

The rural community setting is another key space in which health professionals and undergraduate students' co-construct meanings in rural health education. Rural placements provide undergraduate students with experiential

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<sup>66</sup> Refer to pages 44 in the introductory chapter and 1823 in chapter 3 for discussions of the relationship between space, discourse, power and identity and the importance of some form of spatial analysis in this study.

clinical and non-clinical learning opportunities in rural communities. As such, these agencies were another crucial setting that influenced the rural health education could be constructed. One challenge this posed to the study was the way medical, nursing and pharmacy students undertake their rural placements in different health care agencies, at different times, and for different lengths of time. It was difficult to identify which health professionals and students should be targeted to invite to participate in the research. It was a dilemma that was overcome by using the same rural context as the study location, to observe each of the nursing, medical and pharmacy rural placements. There were many reasons for selecting this study location. These included;

- it was a rural community that the participating university has established as an experiential teaching and learning context for undergraduate nursing, pharmacy and medical students;
- the Department of Rural Health has established a rural health teaching site, which provides undergraduate students, health professionals and staff with accommodation and educational resources;
- the schools of nursing, medicine and pharmacy all had scheduled groups of students to undertake rural placements in this rural community between April and July 2005;
- two pharmacy students were scheduled to undertake their rural placement at the community pharmacy in April 2005;
- five nursing students were scheduled to undertake their rural placement at

the community hospital in May – June 2005;

- two medical students were scheduled to undertake their rural placement at the medical practice in July 2005, and
- as an academic working at the Department of Rural Health, a rapport had been established with many of the health professionals working in the health care agencies.

The rural community setting under study had a rating RRMA<sup>67</sup> 4 and PHARIA<sup>68</sup> 5 rating. Rural communities are small places. People and places are easily identified from the slightest of detail. These features make confidentiality challenging for all rural researchers. In order to protect the confidentiality and anonymity of those who participated in this study there will be no further descriptive information provided about the rural community or the health care agencies in which this study was undertaken<sup>69</sup>.

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<sup>67</sup> The Rural, Remote and Metropolitan Areas (RRMA) classification was developed in 1994 by the Department of Primary Industries and Energy. It is commonly used as the framework by which the various data sources could be analysed for metropolitan, rural and remote zones. Seven categories are included in this classification - 2 metropolitan, 3 rural and 2 remote zones. A RRMA 4 rating relates to a large rural centre with a population between 10,000 – 24,999. These are determined by Statistical Local Areas (SLA) and allocates each SLA in Australia to a category based primarily on population numbers and an index of remoteness.

<sup>68</sup> The Pharmacy Area (PHARIA) is based on an alternative rural classification system, which is known as the Accessibility Remote Index of Australia (ARIA). This system was intended to improve on the inflexible RRMA system through a detailed, yet simple, transparent, defensible and stable set of classifications. The degree of remoteness is determined by as accessibility to 201 service centres. These values are grouped into five categories: 1. Highly accessible 2. Accessible 3. Moderately accessible 4. Remote 5. Very remote. The PhARIA is therefore based on the degree of remoteness determined by accessibility to the nearest pharmacist. A PhARIA 2 is considered as accessibly, meaning there are some restrictions to accessibility of some goods and services and opportunities for social interaction.

<sup>69</sup> A full overview of the procedures to ensure this study was ethical is provided on page 2193 of this chapter.

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### ***Data Source 3. The Field: Curriculum Documents***

Curriculum documents were considered important cultural artefacts in this work because they contained key symbolic meanings that were valued in the academic context. The curriculum documents used as data sources in this study included:

- the unit outlines for each academic unit under study, and
- a student workbook that nursing students are expected to complete during clinical practice experiences.

### ***Data Source 4. The Field: Participant's accounts of rural health education***

Three groups of people were identified as crucial to the pedagogical work of rural health education, including academics, health professionals and undergraduate nursing, pharmacy and medical students. The practice of rural health education is shaped by the way different groups of individuals socially interact. This means that many different paths can lead to the same outcome and many different outcomes from the same event, depending on the context. In other words, the practice of rural health education is messy and chaotic. It is this complexity that influences how knowledge statements can be constructed and verified by individuals involved in pedagogical work.

In a complex social world, individual's experiences are unique and important sources of data for understanding how meaning is created through

their interpretations of rural health education. These experiences can also be understood as the micro-mechanisms of power in rural health education<sup>70</sup>. The way health science academics, rural health practitioners and undergraduate nursing, medical and pharmacy students know, understand and experience rural health education were therefore considered important sources of data.

### **Sampling Procedures**

A purposive sampling technique was used in the process of recruiting the students, academics and practitioners to participate in this research. Purposive sampling techniques involve selecting a sample on the basis of knowledge of a particular population or on the purpose of the study (Hanson, 2006). Qualitative researchers that rely on purposive sampling methods are sometimes seen to be choosing their participants as a function of the phenomenon they are attempting to explain and this has led to accusations of selection bias (Hug, 2003). The academics, practitioners and students provided the opportunity to gain detailed knowledge of the operation of rural health education in undergraduate nursing, pharmacy and medical education. The objective, then, was diversity, rather than a particular type of representativeness. At the same time, however, sampling was a difficult process because while it was possible to identify the groups of interest, it was not easy to clearly define or delimit these populations.

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<sup>70</sup> Please see page 683 in the introductory chapter for the discussion relating to the micro-mechanisms of power and the importance of examining these capillary practices.

Participants in this research were selected by a third party using particular criteria to select the cases and judge them to be relevant. Each Head of school for nursing, medicine and pharmacy at the participating university was contacted and asked to forward an invitation to participate in the research to the academics using the following criteria. Academics had to:

- be actively teaching an undergraduate student of nursing, pharmacy and medicine at the participating university;
- be involved in working with students who were about to enter a rural health care setting for a rural placement during February – May 2005, and
- agree to be involved in the study.

Three academics were invited to participate in this research. These individuals were identified by the Heads of each School of Nursing, Medicine and Pharmacy as having rural health education in their teaching portfolios. Each academic was informed about the study intentions and the procedures involved. Three academic staff that had rural health education in their teaching portfolios agreed to participate in the research (representing one from each of the schools) and their demographic details are presented in Table 11.

Name	Background <sup>71</sup>	Discipline
Jo	Metropolitan (RRMA 1)	Medicine
Georgie	Rural (RRMA 3)	Nursing
Dan	Metropolitan (RRMA 1)	Pharmacy

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**Table 1111111, Academic participant's demographic information**

The academics were each asked to forward an invitation to small groups of undergraduate students who would be involved in rural health education activities to participate in the research [October 2004]. Eight undergraduate students were invited to participate in this research. They were also targeted for this study because they were scheduled to undertake an upcoming rural placement in the identified rural community setting between April 2005 and June 2005. The students were contacted, in the first instance, by the academic unit coordinator and informed of the opportunity to participate in the study [February 2005]. The following selection criteria were used. Students had to:

- be an undergraduate student of nursing, pharmacy or medicine at the participating university;
- be an Australian citizen, permanent resident or have permanent resident status;
- be enrolled as a full time student;
- undertake a rural placement within a rural health care setting during February – May 2005, and

<sup>71</sup> Rural background has been calculated using the RRMA classification system, which was discussed on page 2113.

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- agree to be involved in participant observation.

Eight undergraduate nursing (4), medical (2) and pharmacy (2) students agreed to participate and their demographic details are presented in Table 12.

Name	Gender	Background <sup>72</sup>	Discipline
Lily	Female	Regional (RRMA 2)	Nursing
Elizabeth	Female	Regional (RRMA 2)	Nursing
Ann	Female	Metropolitan (RRMA 1)	Nursing
Bec	Female	Rural (RRMA 4)	Nursing
Todd	Male	Rural (RRMA 4)	Medicine
Will	Female	Rural (RRMA 5)	Medicine
Sarah	Female	Metropolitan (RRMA 1)	Pharmacy
Bronwyn	Female	Metropolitan (RRMA 1)	Pharmacy

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Table 12. Student participant's demographic information

Three health professionals were invited to participate in this research.

These were identified by the academics responsible for organising the rural placement experiences for the students. They were targeted for this study because they were scheduled to supervise students in an upcoming rural placement in the identified rural community setting between April 2005 and June 2005.

Letters of invitation were sent to the managers of the rural health care agencies that were being used to host undergraduate nursing, pharmacy and

<sup>72</sup> Rural background was calculated using the RRMA classification system, which was discussed on page 211.

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medical students during the rural placement [October 2004]. Rural health professionals who would be supervising students during the rural placement were identified by the managers and informed of the opportunity to participate in the study [February 2005]. The following selection criteria were used. Health professionals had to:

- be involved in working with students who were about to enter a rural health care setting for a rural placement during February – May 2005, and
- agree to be involved in the study.

Over two sessions, large groups of registered nurses were informed about the study intentions, the procedures involved with observing undergraduate nursing, pharmacy and medical students during the rural placement. A total of twenty one rural health practitioners therefore agreed to participate in the research, which comprised of sixteen registered nurses, four doctors one pharmacist. The demographic details of the health professionals who participated in the participant observation and the semi structured interviews are presented in Table 13.

<b>Name</b>	<b>Background</b>	<b>Discipline</b>
Judy	Rural	Nursing
Gwen	Rural	Medicine
Stan	Rural	Pharmacy

### Justification of the sampling strategies

It is necessary to justify the sampling procedures that were used in this study. Qualitative researchers that rely on small samples to study the diversity and complexity inherent in human phenomena are sometimes criticised (McPherson & Thorne, 2006). In total, there were 32 participants in this research, representing 8 undergraduate students (2 pharmacy students, 2 medical students and 4 nursing students), 21 rural health professionals (4 doctors, 1 pharmacist and 16 registered nurses), and 3 academics (1 nurse academic, 1 medical academic and 1 pharmacy academic).

There are several ways a small research sample can be justified in qualitative research. Researchers often cite explicit numeric suggestions, such as Kuzel's (1999) suggestion that five to eight participants are sufficient for homogenous groups or Morse's (1994) estimate that six is a reasonable number for a qualitative study. These numbers are cited as if they represent a general justification for the value of studies with small samples. However, it is a practice that essentially isolates them from the methodological context in which they were intended (McPherson & Thorne, 2006). In this study, the sample reflects the reality of rural health workforce patterns in Australia. The ratio of several nurses, to one doctor and one pharmacist in the study sample parallels a similar workforce distribution of health professionals in many rural communities

(Mahnken, 2001).

### **Ethical considerations**

In the conduct of this research endeavour there were many ethical considerations that required attention<sup>73</sup>. In this section, the procedures relating to the conduct of research involving human subjects are presented. These procedures were necessary to ensure standards of morality in terms of what was right and wrong were addressed in the study.

The initial phase of this research process involved gaining authorisation from the University Human Research Ethics Committee for Social Science (see Appendix A). The purpose of such authorisation was to ensure the individuals who participated in this study were protected from unnecessary harm and had provided informed consent. An information sheet outlining the details of the study procedure, the maintenance of confidentiality, processes for complaints or questions, and advice of no foreseeable risks or harm to participants was developed to support an information session conducted with a group of possible study participants.

Meetings were arranged with participants whereupon the proposed study was explained and the information sheet distributed. The participants were encouraged to retain the information sheet. They were also invited to attend a second meeting on the commencement of the rural placement should

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<sup>73</sup> For example, identifying the location of the university.

they be interested in participating in the study. During the second meeting the study processes were revised to ensure the participants were well informed. All participants were advised participation was voluntary. Social research often requires participants to reveal personal information about themselves and therefore should not be forced to participate (Babbie, 2001). In this study, the participants were informed of their right to withdraw at any time without prejudice. At the completion of the second information session the participants who decided to proceed with the study were asked to complete consent forms. The consent forms were completed on the understanding that participants were voluntarily participating in the study with a full understanding of the possible risks to them (see Appendix B). This understanding of consent is formalised in the concept of 'informed consent' (Babbie, 2001).

An important requirement of University Human Research Ethics Committee (Social Science) Board's approval to undertake research is the need to protect the privacy and confidentiality of information that relates to study participants. Privacy and confidentiality are related but distinct concepts. Privacy is defined as '...the state of being free from public attention, interference, or intrusion' (O'Hara & Neutel, 2002, p 75) and confidentiality is defined as '...being entrusted with another's secret affairs' (O'Hara & Neutel, 2002, p 75). It is a useful distinction because it demarcates privacy to be the domain of the participants, while confidentiality refers to the researcher's responsibility to safeguard all information that is used for the purpose of the study.

Maintaining confidentiality of private information entrusted by research participants is one way to protect them from harm (Hanson, 2006). These were particularly important issues in this research because it is well documented that individuals could be harmed as confidentiality in small rural communities is difficult to maintain (Boyd et al., 2007; Curry, 2006; McGrail et al., 2005; Strong et al., 2005; Warner et al., 2005b). In some instances these ethical risks were substantial enough for researchers to discontinue their rural studies (Fraser, 2003; Fraser & Alexander, 2006)<sup>74</sup>.

The ways confidentiality was maintained in this study related to data management, storage and presentation in the thesis write up. Audiotapes and interview transcripts were maintained in a locked filing cabinet on university premises at all times. In line with the NHMRC Guidelines, audiotapes and transcripts will be kept for five years following the completion of the study and will then be destroyed. The transcripts and thesis do not refer to participants by their real names, but instead use pseudonym to protect their confidentiality. While the participants selected their pseudonym, some of these were changed if they were considered to have some indirect identifying features. For example,

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<sup>74</sup> A study undertaken by these authors was commenced as a case study of a project focusing on attitudes of Australian rural general practitioners (GPs) to nurse practitioners. The research was never published because the results raised an ethical dilemma. The researchers were concerned that, despite incorporating strategies for de-identification, the research participants may be identified. Instead, the researchers published a paper reminding others of the need to consider the potential benefits and risks of publishing findings. They state, "... ethically, research projects in small communities may not be publishable if the population is identifiable (with the need to consider the stigma of disclosure on a population or a person)".

one student selected their nickname as their pseudonym, which was subsequently changed by the researcher during the write up. The same techniques were applied to the location where the study took place; all geographic identifiers have been removed and no descriptive information about the rural location in which this study occurred is included in this work.

### **Negotiating access to study sites**

Gaining access to the sites in which the practice of rural health education occurs required some negotiation and how this was achieved is presented in the following sections.

The practice of rural health education occurs in the academic context and also the rural community context.<sup>75</sup> It was therefore necessary to gain entry to the university to talk with academics and also to various health care agencies to observe the students during their rural placements. Access to the sites in which the study was conducted was negotiated [October 2004] with directors, practice managers and owner at the health care agencies involved. Each participating agency was visited to discuss the proposed research activity with staff. During the meeting directors and managers were provided with information sheets about the study and informed of the aims and study requirements.

Although access to the sites was granted, it was continually negotiated throughout the duration of the fieldwork. Hanson (2006) discusses the

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<sup>75</sup> These 'spaces' were described and theorised on page [1863](#).

importance of maintaining access to site under study. Like Bull, (in Hanson 2006), it was necessary to continually reiterate the nature and purpose of the research activities at the rural health care agencies. While agency staff were not the subject of data collection for this study, they were often present during these periods. It was therefore necessary to state and restate the research motives as often as required in the professional context. The value of these sessions was reflected in the way the researcher experienced unobstructed access to sites, and instances of social interaction, of rural health education. The success of the data collection hinged on the high level of planning and maintenance involved in access to the study sites. The data collection procedures are outlined in the next section.

## STAGE 2: DATA COLLECTION USING QUALITATIVE METHODS

This section describes the methods used for data collection through the creation of language texts using document retrieval, qualitative fieldwork and interview methods. These methods allowed the institutional and individual views of rural health education to be captured or described. Such descriptions were important for generating insights into the ways various individuals understand rural health education and construct meanings about rural people, places and practice. These patterns of language use were also rich data sources for the examination of how student identity was shaped. The language texts not only allowed for analysis of how meanings and identities change over time, but also allowed individuals experience to be located within particular sociohistorical

contexts.<sup>76</sup> By focusing on language as the unit of analysis it was possible to align with the dialectical accounts of socialisation. These accounts of socialisation emphasise the importance of capturing the ambiguities and chaotic nature of the process rather than imposing a sense of social order on individuals' experience.<sup>77</sup>

A cyclical process of data collection and analysis was used. In qualitative research, data analysis often occurs while the data collection process is being undertaken because , “... letting data accumulate without preliminary analysis along the way is a recipe for unhappiness, if not total disaster” (Coffey & Atkinson, 1996, p 2). In qualitative research, interpretations are built from the data, whereupon new data is collected in order to examine and elaborate upon these emerging insights (Marshall, 1996). This suggested the need for a flexible research design and an iterative, cyclical approach to language collection, analysis and interpretation. The data collection techniques of semi-structured interview and fieldwork, incorporating participant observation, field notes, and field interviews, were useful for achieving this task. While the data collection and analysis proceeded in a cyclical fashion in the study, these processes are presented in a linear progression in this chapter for the purpose of clarity. The process of data collection and data analysis is diagrammatically presented in

<sup>76</sup> The importance of understanding the socio-historical context of individuals' understandings and experiences of rural health education is discussed in several other sections. These include pages 193 and 363. Socio-cultural theories of professional socialisation and identity formation (page 1753) are outlined in chapter 3.

<sup>77</sup> A more detailed overview of the dialectical account of socialisation is presented on page 573 of chapter 3.

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Figure 5. The specific components of this process, which are also used as the conceptual layout for this section, included;

- creating language texts for analysis
  - fieldwork
    - observation of participation
    - field interviews
    - reflexive diary
  - semi-structured interviews

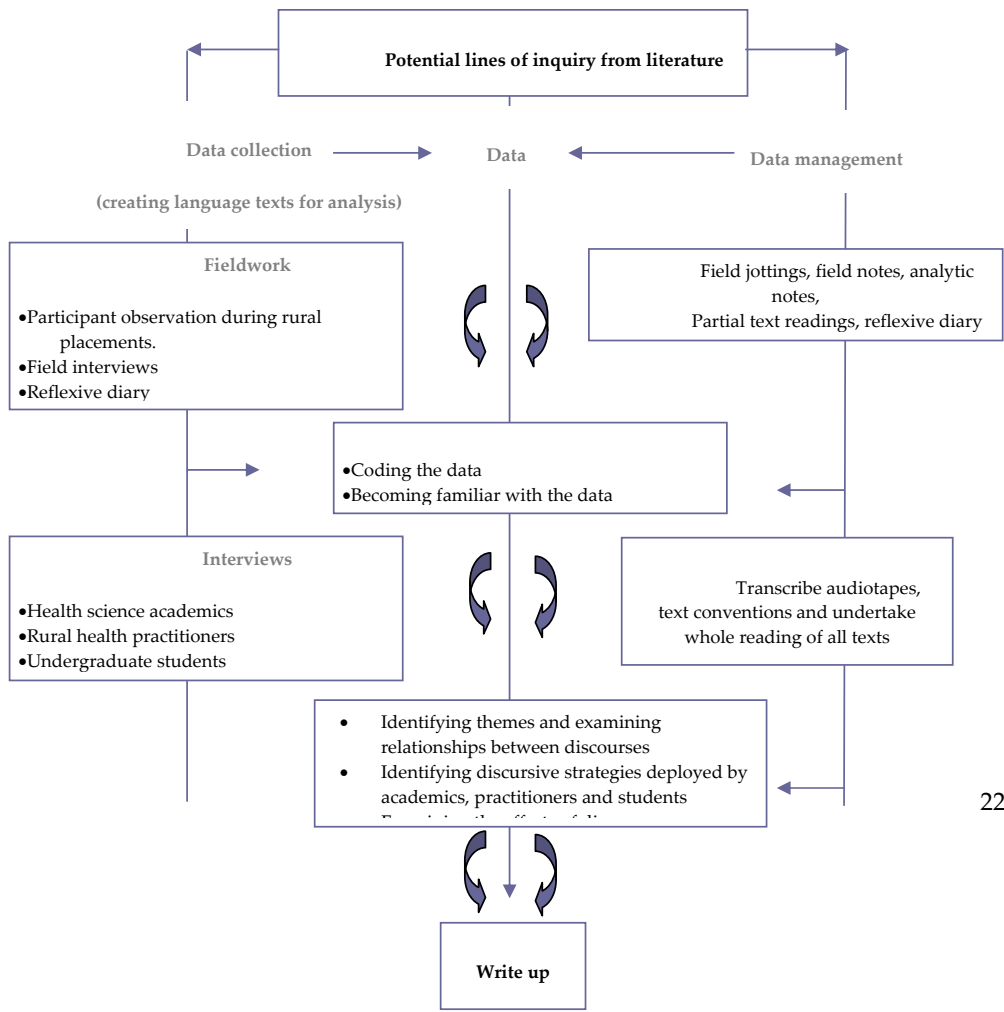




Figure 5555, Cyclical sequence of data collection and analysis

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#### *CREATING LANGUAGE TEXTS FOR ANALYSIS*

In this study, qualitative data collection methods were used to create the language texts for analysis. Qualitative methods were useful for describing the semiotic nature of social interaction between academics, practitioners and students, while simultaneously accounting for the spatial dimensions of rural health education. The techniques of fieldwork and interviewing produced the language texts that came together to form an account of the operational detail of rural health education within the context of the undergraduate nursing, medical and pharmacy programs. Fieldwork and interviewing techniques were effective for collecting data in the multi-faceted real-world contexts of health science education and the rural community. The way fieldwork and interviewing was conducted will now be outlined.

#### **Fieldwork**

Fieldwork techniques were useful for describing the way participants used language on their own terms. By doing so, the trappings of assuming an a

priori relevance of aspects of context were avoided. Critical discourse analysts have attracted criticism for assuming an a priori stance (Babbie, 2001; Billig, 1999; Billig, 1999b; Chouliaraki & Fairclough, 1999; Schegloff, 1998a; Schegloff, 1999b; Wetherell, 1998). By accompanying the nursing, pharmacy and medical students to rural communities while they undertook their rural placement it was possible to observe their social (inter) action while accounting for the social production and construction of time and space. In other words, it was possible to gain empirical access to cultural systems by observing natural events, instead of arranging abstracted entities into unified patterns (DeWalt & DeWalt, 2002). In this way, the sign systems could be described on their own terms.

Fieldwork is the hallmark of qualitative researchers and it requires researchers to observe their collaborators without prejudice or prior assumptions (Hammersley, 1999). Fieldwork is a fluid process that is intended to allow researchers to follow a suitable course of inquiry rather than to dictate in advance what that course should be. The use of qualitative data collection techniques were conceived as "a way of seeing" (Wolcott, 1995) the cultural aspects of rural health education in order to contextualise the data (Blommaert & Bulcaen, 2000). During the period of fieldwork data were collected by uniting the techniques of participant observation, fieldwork interviews and field notes and each of these will now be individually discussed.

### ***Participant Observation***

The technique of observation-of-participation was used to collect data

during the undergraduate students' rural placement rotations. This is a data collection technique that invariably requires the researcher to be present in the field with the study participants (Geertz, 1973; Spradley & McCurdy, 1972). It is based on a traditional method of fieldwork, known as participant observation that was first described by Bronislaw Malinowski as a way of 'going native' (Malinowski, 1922). Essentially this required a continual researcher's presence at the same locations as students would be during their rural placements. It involved staying at the same location as the students, attending various health care agencies (which predominately involved the medical practice, rural hospital, community pharmacy) and social events with the students. During the fieldwork, the intent of achieving a rich, thick description<sup>78</sup> of the culture was realised by following Geertz's (1973) advice to study a cultural group on their own terms. This involved assuming a fly on the wall position by integrating into the daily cultural routines and rituals to conduct the observation of naturally occurring situations rather than drawing attention to the act of observation.

Over the course of six weeks a total of sixty five hours spanning twenty five days were spent collecting data in the field as undergraduate nursing, pharmacy and medical students undertook their rural placements. A comprehensive reflexive diary was also maintained to record the way the researcher's background, knowledge and experience shaped the emerging interpretations.

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<sup>78</sup> 'Thick descriptions' are descriptions of human behaviour that do not just record interactions, but also their context as well (Denzin & Lincoln, 2006).

While participant observation is a way of describing rural health education in action, it is a highly subjective activity. Participant observation techniques are heralded as the ideal way of capturing the uniqueness of groups and a prominent feature of many qualitative studies (DeWalt & DeWalt, 2002). These techniques were challenged when Malinowski's fieldwork diary 'A diary in the strictest term' (Malinowski, 1967), published post humously by his wife, revealed his hidden prejudiced authorial voice and detached cultural position (Denzin & Lincoln, 2006). Contemporary qualitative researchers are more self aware than their early counterparts and this has led to a revision of fieldwork practices (Denzin & Lincoln, 2006). A more humanly and cautious research role in which single texts are blended with personal understandings now exists within the field.

In this study the combination of a reflexive researcher stance and critical edge required a shift from the traditional participant observation techniques to a more contemporary observation of participation. It is a method in which the researcher not only observes the participation of the group under study but also maintains a critical awareness of their own co-participation within the fieldwork encounter (Tedlock, 1991). Observation-of-participation captured what actually happened during the rural placement as well as how these observations were being structured from the researchers' position.

In keeping with the goal to study naturally occurring social interaction in context, the role of observer-as-participant was used to describe and

interpret the cultural interactions between students and others during the rural placement. In qualitative studies, the researcher is the main instrument for data collection (Spradley, 1980). Ongoing observation of the students was achieved through participating in the daily activities of the rural placement. In fieldwork there are degrees of participation along a continuum from complete-observer, observer-as-participant, participant-as-observer, to complete-participant (Hesse-Biber & Leavy, 2006).

In order to fulfil the objective of observing the naturally occurring social (inter) action in the rural context, the majority of the observations took place at the rural hospital. In this context it was possible to assume the role participant-as-observer because as a Registered Nurse it was easy to take on everyday tasks that would facilitate observation in the hospital. By making beds and feeding patients in spaces where the students were working it was possible to see the everyday world from the position of those involved. Participating in everyday activities in the medical practice and pharmacy spaces was more challenging and demanded some creativity.

In the community pharmacy and medical practice the role of observer-as-participant was most often used. This role differs from the participant-as-observer in that it privileges the act of observation but also allows the researcher to participate in everyday activities to advance these observations should the opportunity arise (Hanson, 2006). It is a role that requires the researcher to reveal their identity in the setting. From this perspective the extent to which

the researcher can actively engage with the members of the setting is limited (Hesse-Biber & Leavy, 2006). Hammersley (1995b) warns that if researchers operate in a highly obvious fashion there is a danger that the behaviour of those being observed may be influenced. Ways of blending into the background in the health care agencies were sought to minimise the possibility of influencing natural social action.

In the medical practice access to observation was restricted due to the private nature in which much of doctors consultations take place therefore a great deal of time was 'reading medical text books and taking notes' in the tea room of the medical practice. Likewise, in the pharmacy a significant amount of time was spent 'taking notes' from the pharmacology texts in the dispensing area or cleaning shelves where the medications were housed. These were spaces where many social interactions between the students and the doctors occurred and therefore rich areas for capturing social interaction. Additionally, these activities of participation were initially helpful as they served to build some trust between the researcher and those in the field.

During fieldwork, observation moved from a broad stance to a more focussed perspective to record social (inter)action and contextual detail through thick description. Upon first entering the field, observation commenced from an unfocused stance. With very little knowledge of what would serve for later understandings, or what would become important for analysis, all aspects of social (inter)action were recorded. This is common at the

commencement of fieldwork because the initial observations are not simply representations of the culture; they are shaped by the context in which they occur because they are part of that culture (Hammersley & Atkinson, 1983). The underlying meaning of these observations therefore may not be initially apparent. The 'descriptive observations' (Spradley, 1980) allowed the substantial elements of the students' lives to be recorded. These descriptions represented a collection of the parts of whole system. Qualitative researchers understand this phase of data collection as 'grand tour' (Spradley, 1980) observation.

The process of collecting data through the 'observation-of-participation' was an iterative process. As the rural placement progressed it was possible to interpret the tacit understandings practitioners and students held about various meanings, events and contexts through continual reading and rereadings of field notes to search for things that required further interpretation. While providing a broad descriptive foundation for data collection, the process of observation was soon refined to become focussed on particular areas of social activity. Qualitative researchers refer to this phase of data collection as 'focused observation' (Spradley, 1980). By becoming more cognisant of the cultural aspects of rural health education it was possible to select particular aspects of social (inter)action to observe. This 'selective observation' is the most systematic form of observation, in which the researcher focuses on different types of activities to help delineate the differences in those activities (Angrosino et al., 2000). The observations and emerging analytic insights were recorded as field notes, which



constituted a major set of text on which later conclusions were based.

### *Fieldnotes*

Observations are not data unless they are recorded in some fashion for further analysis (DeWalt & DeWalt, 2002). Each instance of participant observation was recorded in the form of field notes (see Appendix C). Using the guidelines developed by Chiseri-Strater & Sunstein (1997) each set of field notes included:

- Date, time and place of observation;
- Specific facts, numbers, details of what happens at the site;
- Sensory impressions: sights, sounds, textures, smells, tastes;
- Personal responses to the fact of recording field notes;
- Specific words, phrases, summaries of conversations, and insider language;
- Questions about people or behaviours at the site for future investigation, and
- Page numbers to help keep observations in order.

As the focus of data collection was on social interaction it was imperative to generate precise and accurate accounts of the spoken exchanges between the students and others. Quite often this required a departure from the field to expand upon the recorded interactions to write up descriptions of the occasion by recalling other details about the participants' non verbal actions and the environment. These details were relevant for linking related phenomena to one another during periods of analysis, as Chiseri-Strater & Sunstein

(1997) had advised. Sometimes during periods of participant observation and note taking, insights about those situations emerged. It was also necessary to record these.

Analytic notes were incorporated into some field notes (see Appendix D) however these were always marked to distinguish them from the observed recordings. Such notes were useful for advancing the depth of the interpretations, because they could be used during periods of intense analysis when considering how power, discourse and cultural processes were working in the various contexts of rural health education. Sometimes, there were periods in which the observed situations triggered personal and emotional responses. These reflective episodes were also recorded separately from the observation notes. At other times, it was inappropriate to record field notes during the actual observation and in these instances 'jottings' were recorded and developed into field notes at a later stage. To preserve the integrity of the spoken words, instances of social interaction were never recorded through jottings.

### ***Field Interviews***

During the periods of fieldwork there were instances in which interpretations of what was going on was abstract whereby real meaning escaped. At other times, interpretations were so subjective that it was possible to identify so completely with the students that there was some risk that other

meanings might be overlooked. Geertz (1983) suggests that while striving to be 'inside and outside' simultaneously is impossible, proceeding toward that dual perspective and being alert to avoiding the problems of abstraction of the outsiders' perspective and the subjectivity of the insider's perspective is important. To facilitate this dynamic position, the informal fieldwork interviews were used to talk with participants who were considered to be helpful in providing a historical context for understanding much of what went on during the rural placement.

Two styles of informal fieldwork interviews were used during the rural placement, including informal unsolicited interviews and informal solicited interviews (see Appendix E). To facilitate the process of interpretation it was necessary to clarify aspects of student's interaction and mediate discourses against other culturally meaningful dimensions through interviews. Whenever it was necessary to clarify cultural aspects of social (inter)action informal interviews were 'solicited' (Hammersley & Atkinson, 1995a) from students. These could be achieved by creatively asking students informal questions to explore the culture from their point of view. Not only did this capture elements of the culture that were important (Austin-Broos, 1987), it also provided information about the students' account of reality.

At other times, the students or other people in the field raised and spoke about issues of their own volition. These unsolicited accounts were often strong indicators of the interplay between agency and structure, knowledge

and power, ideology and identity. While there are slight differences between these styles of informal interview they were both regarded as "social phenomena occurring in, and shaped by, particular contexts" (Hammersley & Atkinson, 1995a, p 156). At the same time, the unsolicited field interviews were often an important source of data that contained strong taken-for-granted notions relating to rural health education. The field was often an inappropriate space to discuss many of the issues that emerged from the field observations or interviews. These issues were therefore examined in more detail, with particular academics, practitioners and students, in semi-structured interviews.

### **Semi-structured Interviews**

The style of the semi-structured interviews with the academics, health professionals and students was conversational and interactive. Informal open-ended questions were used to invite the participants to talk about their involvement in, and experience of, rural health education from their point of view. The style of interviewing therefore required the use of broad open ended questions (Spradley & McCurdy, 1972). For example one interview question was, 'tell me about your experience of rural health education?'. These questions engaged the academics in a way that allowed rural health education, as the topic for conversation, to be introduced with care being taken to not overlay a particular interpretation into the questioning.

The goal of data collection was to collect the way academics, practitioners and students talk about rural health education on their own terms. It

was crucial that the interaction was not structured by the researcher but instead an attempt to capture interaction that would have taken place in the form that it did if the researcher had not been present. As such, there were three characteristics that influenced the way the interviews were conducted.

First, there was an implicit expectation the participants would account for their answers in ways that would allow their accounts of rural health education to be queried further. Second, the interviews were designed to extract diversity in answers from various individuals; the style was therefore interactive rather than formally structured. The interactive nature of the interviews assumed that no fixed sequence of questions was suitable for all individuals therefore participants were allowed to use their 'unique ways of defining the world' (Denzin, 1970). The participants were encouraged to raise issues that were important to them. Third, as the researcher is positioned as an active participant in the research process the line of questioning formed part of the text of the discourse analysis.

A total of ten in-depth one-hour semi-structured formal interviews were conducted with the research participants. These included interviews with four students, (being two nursing, one medical and one pharmacy student), three academics, (including one nurse, medical and pharmacy academic) and three health professionals (including one registered nurse, doctor and pharmacist). Those participants who agreed to participate in the interviews were asked to nominate the day they could be conducted and at a location where they would be comfortable. For example the nursing students were interviewed at

the School of Nursing and the medical student was interviewed at the clinical school.

The participants who were invited to participate in the interviews were selected on the basis that they were prominent in the fieldwork notes, with the additional advantage that they were able to clearly articulate their experience in concrete terms. According to Spradley (1979) it is advisable to select people, who are known as key informants, to interview who are helpful in providing a historical context. Likewise Hammersley & Atkinson (1995b) advise that informants help by making sense out of what has been observed in the field. In speaking with participants it was important to listen carefully to what they said and regard what they spoke about as real and honest accounts. Despite the extensive global literature search there were no studies that examined rural health education at deep theoretical or contextual levels or that did not privilege the researcher or educationalists voice while oppressing the voices of those who actually experience rural health education.

One challenge in this research was to allow the academics, practitioners and students to have a voice in way that had not been done before in rural health education inquiry. By working from a position of respect for, and interest in, the participants, this was achieved by creating an interview environment that reinforced the notion that their perspective and their view of this educational work were important and valuable. This style is characteristic of the interpretive and interactional approach in which the researcher is concerned with

how people live and give meaning to their lives and seeks to capture these meanings in written and spoken forms (Denzin, 1989). All of the interviews were audio-taped; however these spoken records could not be used directly.

Talk can only become research data if it is captured, recorded and transcribed into a format that can be analysed. The audio-recordings were transcribed to reconstruct the interactive events while detailing non-verbal behaviours. Just as Potter (1996) warned, this was labour intensive because even simple aspects of interaction such as pauses, interruptions and simultaneous talk were marked to facilitate a discourse analysis. Nevertheless, the process of transcription often gave rise to some of the most revealing analytical insights. In light of this, analytic notes were often recorded alongside the text at the time of the actual transcription. Such analytic insight occurs because a profound engagement with the material is needed to produce a good transcript (Potter, 1996).

The talk was transcribed verbatim and the desire to correct 'errors' was avoided in the endeavour to preserve the sequence of whole, meaningful words and meaningful non-lexical vocalisations (Silverman, 1993). The transcripts were therefore not "a neutral, simple rendition of the words on a tape" (Ochs, 1979 in Potter 1996) but instead an attempt to produce the character of the speech activity. A number of conventions were used to mark particular aspects of speech and the non linguistic aspects of talk and these are presented in Figure 6.

Convention	Description
Yes	Capitals indicate emphasis
[laughs]	Paralinguistic features
.	Pause less than one second
+	Pause greater than one second
[	interruption
( )	Indecipherable speech
-	Incomplete utterance
...	Section of transcript omitted

Figure 6666. Transcription conventions

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The interview transcripts provided a set of written data through which the relations of power, knowledge (discourse) and identity within rural health education could be examined, described and interpreted. By bringing together the language texts, generated by the field notes and interviewing techniques, it was possible to examine the academics, practitioners and students use of language to analyse the practice of rural health education. Alone, the texts would have been insufficient for characterising the whole system of rural health education and fail to reflect the powerful ideologies at work in other levels or the accounts of other participants.

The next section discusses how data were analysed in the study.

### STAGE 3: ANALYSING THE TEXTS



In this section the assumptions, principles, and techniques that were used to gain insight into data via critical discourse analysis are discussed. It begins by illustrating a complex tripartite system of coding that involves processes of induction and deduction using the NVivo qualitative software for analysis. The linguistic techniques for analysing grammar, vocabulary, and discourse analytic techniques for analysing modality, transitivity, intertextuality and assumption in texts inherent in critical discourse analysis, as espoused by Fairclough (1995b) are described. The discussion focuses on the way the analysis moved back and forth between the elements of text, discursive practice and social practice to explain how the relations of discourse and power at the macro level work to influence those at the micro level and how these relations impact on the way students shape their social identities.

### **Coding the data**

The first part of data analysis involves coding the data. Coding was an important initial phase that preceded the indepth data analysis. The coding procedures used for each of the texts are described in this section.

A multileveled approach, incorporating inductive and deductive methods was used to code and analyse the texts. The total volume of text generated by the semi-structured interviews and techniques of fieldwork was copious. Fifty eight separate sets of field notes (including field interviews) amounted to two hundred and ninety four pages of double spaced text (or 71,812 words). Furthermore, ten interviews amounted to another one

hundred and thirty seven pages of double spaced text (or 44, 631 words). The cyclical nature of data collection and analysis facilitated a process of analysis being sequentially undertaken and this was an effective way of handling what was to become a substantial collection of text. Another way of managing the volume was to treat the data sources as separate manageable segments for the initial coding and preliminary analysis. The coding sequence is diagrammatically presented in Figure 7.

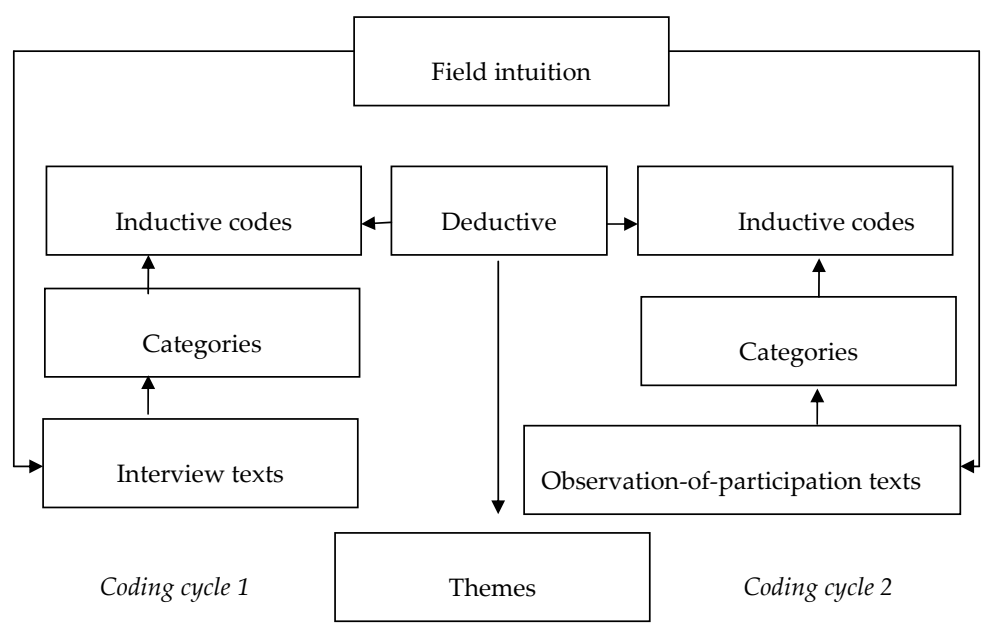


Figure 7777, Data Coding Sequence

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The first texts to be analysed were the transcripts of the academic interviews. Using the computer assisted software QSR NVivo ® (2006) the transcripts were coded by attending to the text using a whole reading approach (Manen, 1997, p 3) to inductively identify broad meanings (see

Appendix F). These meanings were organised into categories to isolate the discourses at work in other academic discourse and identify the way rural health education was understood in the undergraduate programs under study.

The second stage of the data coding involved the examination of the texts generated during the participant observation of nursing, pharmacy and medical student's rural placement. Initially these texts were approached as a separate data set to that in stage one and used the computer assisted software QSR NVIVO® to inductively code them. Once again this involved attending to the texts using a whole reading approach (Manen, 1997) in a non linear way to inductively identify aspects that were recurring. Care was taken to ensure these recurring aspects were assigned to codes that reflected the content and this often relied on the language used by the participants.

The third stage of data coding involved the re-examination of both sets of texts (academic interviews and participant observation field notes). Using the codes from the first and third stage of analysis, a deductive approach was used to search for instances in which discourses influenced participant's social interaction. The texts were also searched for instances of power using a set of codes derived from the theories of power and identity outlined in chapter 3. The set of codes, were as follows:

- surveillance: observing, watching;
- normalisation: requiring, conforming, defining the normal, and

- technologies of self: coercion, self governance,

These instances of power were closely examined to determine if there were connections between discourse, power and the way students shaped their personal and professional identity. Where connections were identified these were assigned a secondary code and incorporated back into the set of data samples. The use of both inductive and deductive coding is in line with the critical approaches to discourse analysis (Wodak et al., 1999).

While the NVivo program facilitated the effective and quick process of assigning codes to the data it was necessary to see the data in its totality impeded analytic effectiveness. The constraints imposed by the NVivo software impeded by ability to 'see' the coded data in its entirety. The texts were therefore printed from the NVivo program, which allowed the coded sections of texts to be highlighted. From the coded sections it was possible to manually extract data samples and attach these to index cards. Using a numerical classification system each card was assigned a number to record the location of the samples in the original text and the type of data (for example, actor, discipline, field note, informal solicited interview, informal unsolicited interview or formal interview).

Each data sample was colour coded to allow the discipline to which the sample related be recognised (i.e. nursing, pharmacy or medical). Details of the classification system are presented in Figure 8. Once the texts had been mounted onto index cards and subjected to the three stages of coding it was possible to

manually arrange the samples into categories.

NS	Nursing student	FI	Formal interview
MS	Medical student	IUI	Informal unsolicited interview
PS	Pharmacy student	ISI	Informal solicited interview
NA	Nurse academic	FN	Field note
MA	Medical academic	PA	Pharmacy academic

**Figure 8888. Classification system for identifying data samples**

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Once the texts were coded and themes were categorised, a more intensive process of data analysis was undertaken.

The critical discourse analysis framework and analytic tools described by Fairclough (1989, 2001) were used for an indepth analysis of the language texts<sup>79</sup>. Following Fairclough's guidelines, the texts were examined for meaning and identity themes. This was achieved by;

- looking at how individuals constructed the boundaries of the pedagogical space for rural health education;
- looking for ways individuals constructed rural people in language, and

<sup>79</sup> Creation of the language texts for analysis was discussed on page 2263 in the previous section.

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- by examining identity themes<sup>80</sup>.

Each of these analytical steps required some analysis of ‘orders of discourse’ (Foucault, 1994) and the grammatical features shaping the texts. Some of the main criticisms of critical discourse analysis pertain to analytic limitations (as discussed in chapter 3). In this section, the procedures used during the analytic process are presented and discussed in detail.

In critical discourse analysis there are three interwoven levels of analysis – the text level, the discursive practice level and the socio-cultural level<sup>81</sup>. For each of these levels there is also selection of sixteen analytic techniques from which researchers choose according to their specific research requirements. For instance, in this research the field notes were heavily laden with visual semiotics and the interviews required more linguistic textual analysis. Fairclough (1992, p 1) suggests “... it is necessary to draw together methods for analysing language within linguistics and language studies, and social and political thought”. Customised methodologies, argues Fairclough (1992, p 1), will end the “... isolation of language studies from other social sciences and a tendency to see language as transparent”. As Atkins (2002) shows, to apply all of the analytic techniques limits the researcher to a small amount of text and does not necessarily deepen understanding. The analytic tools used in this research included:

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<sup>80</sup> Chapter 3, page 1933, discussed possible ways of isolating indicators of identity formation in spoken language. References to “them” and “us” or “similarities” or “differences” are examples of identity expression.

<sup>81</sup> These analytic levels were discussed in more depth on page 2023 of chapter 3.

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- assumption,
- word meaning,
- intertextuality,
- transitivity, and
- modality.

These analytic techniques were of most use in this research because they drew attention to the interrelated elements of meaning, structure, identity and human agency.

A step by step process was used to analyse the data. It combined the theoretical lenses of professional socialisation and identity formation, and the analytic concepts and tools of critical discourse analysis. These steps included;

- becoming familiar with the data
- identifying themes and examining relationships between discourses
- identifying discursive strategies deployed by academics, practitioners and students, and
- examining the effects of discourse.

### **Becoming familiar with the data**

As the data were collected it was subjected to multiple readings to establish the function of the texts. The tools used in the level of analysis included the linguistic analytic techniques of vocabulary, grammar and

propositions, as described by Fairclough (1989, 2001). These techniques were used to subject the texts to a 'textual analysis'. According to Fairclough (1992) this involves examining the ways the text is structured and organised. The texts were examined in terms of word use (vocabulary), the ways words are used together (grammar) and the meanings inherent in the texts (propositions). From the textual analysis Fairclough (1995b) argues it is possible to uncover the functions or uses of the texts. For example, calling particular people 'students' worked to construct their social identity. References to 'work' were associated with performing clinical or professional tasks in a health care agency as well as writing up an assignment during the rural placement. These descriptions were considered as actions that elaborated context. In other words the textual analysis served to examine the semantic function of language used in the rural health education texts. It was not, however, possible to simply read meaning directly off the textual signs therefore the textual level of analysis was considered as a heuristic device; as a place to commence the analysis.

Language rarely expresses meaning directly therefore the texts were subjected to numerous readings aimed at examining the taken-for-granted assumptions and understood as common ground understandings (also known as common sense). While common ground assumptions were sometimes explicitly expressed in the texts, the majority of the time they manifested in less obvious ways. Fairclough (2003) differentiates between three kinds of assumptions: existential assumptions (assumptions about what exists), propositional



assumptions (assumptions about what is and what will be) and value assumptions (assumptions about what is good or desirable).

An important aspect that required attention during the analysis of assumption was to not take texts at face value, but to consider whether the speaker was being 'indirect'. For the majority of the time, the meaning of a word is taken at its face value in social interaction. While it is possible to use a dictionary if there is any doubt about the meaning of a word, this will only ever provide the most literal meaning of a word. Literal word meanings are known as denotation (Eco, 1987). According to Fairclough (1989, 2001) there is considerable variability of meaning amongst language users as well as considerable variation in meaning systems within groups. Here, the term connotation refers to all the associated meanings, which the listener/speaker may take from the text (Eco, 1987).

The variability of meanings is not just randomly generated but corresponds to different ideological positions. An important aspect to consider in the data analysis. In the texts particular words and phrases, such as the generic health professional, were dominant in the academics texts. The fixed meaning of these utterances is an effect of power, the sort of ideological effect, which Foucault (1972) and Fairclough (1989, 2001) call normalisation<sup>82</sup>. Connotation, argues Eco (1987) refers to degrees of indirectness in which context is communicated and denotative meaning is the most direct meaning. The

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<sup>82</sup> The concept of normalisation was discussed on page 1873 of chapter 3.

interpretive endeavour at this stage of analysis was to discover all the relevant connotations of the texts. This required attention to the textual, situational, social, and cultural and institutional content. Decisions about which of the connotations were most likely intended by the speaker were contingent on some understanding of the nature of the context, for example the social institution of health care work. Interpretation therefore required reference to other statements made in the texts as well as the current context of the pedagogical activity.

As the data amassed and the common sense assumptions became more familiar the texts were examined for intertextual relationships between them. Texts contain a variety of other texts whose presence may or may not be explicitly acknowledged (Fairclough, 1995b). It was therefore necessary to examine the texts to identify patterns of regularity across the statements. The process of construction of a text with other texts is known as intertextuality. Intertextuality implies the insertion of history in the text (Kristeva, 1980). It is a contribution in discourse that imports other voices into a text and consequently relates to other people's discourses (Kristeva, 1980).

The analysis of intertextuality required a deep familiarity with the patterns of statements across the texts therefore a deep immersion in the textual world of rural health education was necessary. In this way the data became known in a deep way that had meaning beyond a familiarity with the context of the texts. Here, the concept of assumption can be further clarified as the notion of reducing difference by assuming common sense and omitting explicit

relations to other discourses. Fairclough (1995b) argues that a message which includes connections to other people's ideas is more likely to be received as open and approachable, whereas undialogised language may be considered as authoritative and absolute. These analytic techniques were particularly useful for interpreting how the boundary of the pedagogical space for rural health education was defined in similar ways by different groups.

The intertextuality of the texts was analysed by distinguishing between manifest intertextuality and constitutional intertextuality. Intertextuality is manifest when the presence of other texts is explicitly acknowledged by the author. This can occur through either direct speech, quotation marks or indirect speech (Fairclough, 1992). The existence of another text is not always acknowledged by the text. In these instances categories are used, which are entire historical registrars, to constitute the text. This is known as constitutional intertextuality (Fairclough, 1992).

In the analysis of the pedagogical space for rural health education it was important to identify who was talking to determine within the compositional structure of the texts, the vehicles for ideology. For instance, sometimes students spoke through a voice they had accessed from another source and at other times they used more personal narrative. In other words, the different sources students drew upon in the pedagogical space for rural health education reflected a plurality of ideological positions. It was therefore important to consider the

speaker's direct comment on the ideational nature of the talk. This is known as modality.

The analysis of modality made it possible to interpret the way the research participants consume and reproduce discourses. According to Fairclough (1992, p 177) modality can be described as the 'mood' of the text. A modality analysis refers to the technique of examining the text for the interpersonal function of grammar (Fairclough, 1992). The rural health education texts were analysed to determine how language was modalised by various speakers by searching for modal verbs such as 'may', 'might' and 'seem', and modalised sentences. Fairclough (2003) stresses that modality choices are an important part of texturing identities; what people commit to in any kind of discourse, is closely related to their identity.

### **Identifying themes and examining relationship between discourses**

It was through the process of analysing and re-analysing the rural health education texts that themes began to emerge. As more data were collected, it became easier to identify categories and objects of the discourse. These objects of discourse referred to how rural people, places and practice were referred to in the rural health education texts, how often they were referred to, and what concerns emerged in the academic and rural community spaces. Several themes were identified during this phase of data analysis. These included;

- undergraduate nursing, pharmacy and medical education appear to be

focused on generating generalist health professionals and in a pedagogic sense this is presented as common sense;

- academics are uncomfortable with the responsibility for teaching rural health content and it is therefore rendered invisible by the way it tends to be embedded within 'everyday routines' associated with generalist health science education;
- rural health education is constructed as a rural placement and in a pedagogic sense this is presented as common sense;
- health professionals also understand rural health education as a form of generalist core curriculum but also see it as an opportunity to attract students to rural practice and life;
- at all levels of rural health education students are informed that rural people, places and practices are different and disadvantaged and in a pedagogic sense this is presented as common sense and therefore never quantified.

Once these patterns were discerned across the rural health education texts they were re-examined with the national rural health education literature. The purpose of this level of analysis was to determine how the discursive formations and strategies might be shared between the micro level rural health education texts and the macro level of the broader undergraduate nursing, medical and pharmacy education texts. According to Phillips (2002, p 70), discourse is always three dimensional in that it always "connects texts to discourses, locating them in a historical and social context, by which we refer to particular actors,

relationships and practices that characterise the situation under study". This level of analysis once again involved searching for evidence of inter-relationships among and between discourses using the techniques of inter and intra textuality that were described earlier in this section. These investigations compared the various texts across time, and within similar time periods, across different genres, and against statements within the rural health education text. The themes identified from this analysis of rural health education texts were organised into three main categories;

- understanding rural health education as a component of generalist health professional education,
- justifications for including a rural placement in nursing, medical and pharmacy education with an absence of rural health pedagogy,
- constructing rurality as 'other' through discourses of difference, disadvantage, idyll and ordeal.

The features of these discourses and categories for analysis are defined in the context of the analysis of rural health education knowledge in chapters 5, 6 and 7.

### **Identifying discursive strategies deployed by academics, practitioners and students**

Once the discourses were analysed in terms of how different groups were shaping the pedagogical space for rural health education, constructing meanings about rurality and creating identity making opportunities, the analysis

considered how these perspectives were sustained. There are several strategies that can be used in discourse to normalise certain subjectivities and exclude others. Foucault (1975) cites three main strategies to be responsible for the success of disciplinary power<sup>83</sup> in constituting objects as 'hierarchical observation', 'normalisation' and the 'normalising gaze'. In hierarchical observation, the disciplinary apparatus makes it possible for a single gaze to observe all social action. The language texts were examined to interpret the ways continuous surveillance upon the undergraduates students resulted in their succumbing to mechanisms of 'coercion' or 'self regulation'.

The data was examined for processes of normalisation and exclusion by examining processes of comparing, ranking, classifying, hierarchising, and dividing (Foucault, 1975). Hierarchical observation and normalising judgments combine to form a normalising gaze, which makes it possible to qualify, classify and punish (Foucault, 1975). These strategies, argues Foucault (1975), can successfully transform individuals into compliant and useful individuals who are equipped to serve the state. In the rural health education texts these strategies worked to influence the students to behave in ways that aligned with the prevailing belief systems and values of the cultural institutions in which their pedagogical experiences took place. In other words, the discursive system of rural health education is structured in ways that serves the ideological interests of undergraduate nursing, pharmacy and medicine and establishes specific

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<sup>83</sup> Disciplinary power is discussed in detail on page [683](#).

forms of student subjectivity through acts of normalisation and exclusion, which is discussed further in chapters 5, 6 and 7.

In rural health education the legitimization of certain goals and means serves to constrain choices even though it cannot predict more than a range of possible choices. Here the main emphasis lies on the constitutive function of discourses through which meaning, identity and legitimacy of patterns of activity are established. Hence the main analytical task was to investigate the mechanisms that provided these signifiers with meaning. This mechanism is the process of legitimization which produces the ascription of purpose and meaning. The issue of legitimacy is of specific importance to this study because rural health education is a politically motivated educational activity with multiple decision making centres therefore the question of legitimacy establishing the guiding rules and regulations is of heightened relevance. By analysing legitimization, as described by Fairclough (1995b), it was possible to interpret the legitimizing claims in rural health education. The language texts were also examined to determine the general intent of the speakers, their degree of commitment to the signification of their worlds and their overall credibility.

### **Examining the effects of discourse**

Finally the analysis concentrated on examining the consequences of discourses in terms of how power and knowledge were valued and circulated in rural health education. Essentially this involved examining the effects of rural health education discourses as well as identifying who benefits and



who does not. Discourses are regarded as instruments of power, but also effects of power capable of changing and disrupting the relationships of power (Foucault, 1980). By attending to the discursive effects it was possible to consider the ways in which the discourses constitute rural health education in undergraduate nursing, pharmacy and medical programs. These are discussed in detail in chapter 7.

## ATTENDING TO ISSUES OF RIGOUR

All researchers, no matter how well they design or execute their research must attend to its inherent limitations. There are three criticisms levelled against critical discourse analysis. Firstly, it is argued that the approach too easily allows a researcher to uncover the findings they were expecting or wanting to find, which relates to analytical issues. Secondly, critical discourse analysis has been criticised on grounds of generalisability. Thirdly, critical discourse analysis is said to lack methodological rigour. These shall each be addressed separately and accompanied by an explanation of the limitations they impose on the research and how these were attended to in this study. In this section the assumptions about rural health education that pre-existed the research are made explicit to the reader, the notion of generalisability is discussed, and when and why particular choices were made during the research process is made transparent to readers. Rigour was maintained by developing an audit trail, maintaining a reflexive diary and a research log.

## Issues of Analysis

Critical discourse analysis involves a complex set of analytic techniques.

The main analytic struggles that Antaki et al (2003) identify, relate to;

- under-analysis through taking sides;
- under-analysis through summary;
- under-analysis through over-quotation or through isolated quotation; and
- analysis that consists in simply spotting features.

In this study, many of these analytic issues were avoided through the careful and detailed conceptual and theoretical planning of the research. The trap of taking sides was avoided by conceptualising rural health education as a contested pedagogical space to which different groups bring their ideological understandings to shape meaning- and identity-making possibilities. Meaning and identity was identified from the data, rather than by operationalising existing constructions. Understanding rural health education as a process of socialisation and identity formation was another way of allowing the empirical insights to emerge from the data.

A detailed analytic framework guided the systematic analysis of the data. There were many iterations and levels of data analysis, which allowed the text to be examined both as a set of parts and also as a whole. The coding and categorisation, and cross referencing and continually re-reading of the language texts ensured the development of robust themes that could be well substantiated

by the data. These procedures ensured the write up process was more detailed than a summary reliant on participant's quotations.

### **Issues of Generalisability**

While this study of rural health education was located in a wider socio-historical context than has been previously examined, it must be acknowledged that the findings of this study do not seek to be generalisable. The small sample size allowed for the rich thick description of rural health education. It did not however, allow for generalisable claims to be made about rural health education. No claims about generalisability or truths are made in this thesis. In qualitative research, the adequacy of the sample size is determined by the depth and richness of the data (Hanson, 2006). The focus is on the generation of rich, thick descriptions of the phenomena of rural health education rather than the pursuit of truth or generalisable arguments.

### **Issues of Rigour**

While some of the terms used in this research are similar to those used in research based in quantitative scientific paradigms, their intent is different. Because this study was based in a critical constructionist paradigm it sought to establish the authenticity, rather than the reliability and validity, of the findings. As such, the special criteria developed for assessing the quality of qualitative research were used. These essentially relate to the notion of trustworthiness.

## **Trustworthiness**

The descriptive validity and unique qualities of this research are established through the qualitative referents of trustworthiness. Validity is a quantitative term that refers to a set of micro definitions relating to description and explanation so the reader can determine whether the explanations generated in the research are credible (Denzin & Lincoln, 2006). In line with the qualitative framework used in this study, this position is rejected. Instead the multiple ways of interpreting accounts are embraced and therefore no one 'correct' interpretation can be applied to rural health education. Qualitative techniques for establishing trustworthiness of the findings generated in this research are taken from the suggestions of Lincoln & Guba (1985) who have been writing about ways of establishing rigour in qualitative research without relying on the traditional quantitative measures.

The fundamental question that underpins the trustworthiness of qualitative research findings is: "How can an inquirer persuade his or her audiences that the findings of an inquiry are worth paying attention to, worth taking account of?" (Lincoln & Guba, 1985, p. 301). To assist qualitative researchers in developing arguments about the trustworthiness of their findings Lincoln & Guba (1985) have developed four criteria, including credibility, transferability, dependability, and confirmability. The ways this study achieves these criteria are now discussed.

## **Credibility**

There are many strategies for improving the credibility of findings and interpretations produced in qualitative research. In particular the strategies recommended by Lincoln & Guba (1985) have been well recognized for improving the likelihood that findings and interpretations produced through qualitative research will be credible. Two of these strategies are peer debriefing and member checking.

The first strategy for establishing credibility in this study involved peer debriefing. Peer debriefing involves a peer or colleague, who has no association with the research, for the purpose of exposing analytic interpretations that may have otherwise gone unnoticed (Lincoln & Guba, 1985, 308). The peer debriefer for this study was Sue Whetton, a doctoral candidate and lecturer in health informatics at the University Department of Rural Health. Throughout the research there were many conversations with the peer reviewer concerning the study, such as methodology, data, theoretical perspectives and emerging insights. These were invaluable for strengthening the research as a whole and clarifying parts of the analytic interpretations.

The second strategy for establishing credibility in this study involved member checking. This is a process that involves the research participants in the research during the analytic phases (Lincoln & Guba, 1985). Through the cyclical process of data collection and analysis participants were engaged in conversations concerning the researcher's interpretations and emerging insights.

A significant amount of the data and its analysis has been verified through this process.

### **Transferability**

The interpretations and analysis of data in this study was dependent on specific contexts and interactive dynamics between many individuals. In a quantitative study this aspect of the study might be regarded to impede the possibility for external validity. In qualitative research, however, interpretation is reliant on "thick description" (Patton, 1990). From comprehensive and detailed descriptions of the language used by academics, health professionals and students it was possible to improve the studies' transferability. Others may be interested in applying the findings of this study to their own work. To assist with this decision the thick description of the experiences of academics, health professionals and students involvement in the practice of rural health education are provided.

The fact that another may interpret the same data set differently depending on the choice of theoretical perspective, or spatial-temporal orientation should be embraced. The more interpretations researchers can make of complex phenomena the more knowledgeable society becomes. Indeed, it is through this system of proposal and critique that it will be possible for theories of identity to progress and develop. Interpretations of the influence rural health education has on the way undergraduate students develop their professional identities should resonate with other readers who are involved with

rural health education within undergraduate nursing, pharmacy and medical education. Further investigations of the influence of rural health education on undergraduate nursing, pharmacy and medical student's identity formation will make a valuable contribution to these interpretations.

### **Dependability and confirmability**

The dependability and confirmability of this research is determinable through the rigorous audit trail that has been maintained. According to Lincoln & Guba (1985) auditing allows another individual to determine whether the process was applicable to the research undertaken and whether it was applied consistently (Lincoln & Guba, 1985).

When and why particular choices were made in this research are made transparent by developing an audit trail, maintaining a reflexive diary and making explicit the ways the limitations to the research were attended to. All research is ideologically driven (Denzin & Lincoln, 2006) therefore there can never be a value-free or bias-free design. It is essential the research identifies their biases and articulates the ideology or conceptual frame for their interpretations (O'Leary, 2005). Rigour in research therefore requires a high degree of reflexivity and critical analysis. By keeping a reflexive journal throughout the research process it was possible to make explicit how the personal situation and background of the researcher influenced the interpretation of the participants situations (Koch, 1994b).

In this way the reader should be able to draw conclusions about the dialectical nature of the study and identify the way the students and researcher interacted within an interpersonal discourse that was the outcome of a process of negotiating meaning. The problems of practice are viewed as an active interface between the researcher, the setting and the actions within the social context (Kremmis 1995, 24). All interactions were co-produced and 'structured' by both the researcher and the social actors who participated in the study (Hammersley & Atkinson, 1983, p 110-111). Having accepted Fairclough's (2003) view of openness of the social world it was necessary to be theoretically self-conscious and reflexive for the empirical research. The reflexive journal, advocated by Koch (1996) was one way to record the researcher's involvement in the study.

The reflexive journal contained information about the researcher, what was done, and the process of research. It was used to complement the data yielded by the research methodology. By documenting thoughts and ideas throughout the research process, the basis of understandings were continually confronted during the process of combining the outsider and others insider accounts. In order to encompass new situations they firstly required understanding of individual elements and then re-examination in terms of the whole picture. By charting details of experiences as a researcher, student, colleague and parent it was possible to examine the ways each of these multiple existences impacted on the researcher's voice.



The reflexive process involved constant movement backwards and forwards between the inside and outside, making the familiar strange and the strange familiar (Erickson 1986, p 121). The reflexive journal entries facilitated continuous dialogue between participation and detached analysis. The act of journaling deepened self-awareness and sharpened reflection, thinking and communication. According to Janesick (1998) these attributes increase the effectiveness of the researcher as a research instrument. By making the researchers voice audible during the research process, it was possible to present the construction of the research method as an active interface between the person, the practice and critical reflection. Working the theory and practice together in this way, the issues of method, data, validity and analysis in the methodological framing of the research were clarified.

A research log was also maintained however this was different to the reflexive journal in that it was used to systematically track what was being done throughout the study process. The research log provided a chronological research record containing progress reports, memos, supervision meeting notes and other comments. Recording such critical incidences for the duration of the study was a decision based on the work of Tripp (1993) who operated from Schon's (1983, 1991) conception of the reflective practitioner. According to Tripp (1993) routine occurrences are indicative of underlying trends, motives and structures, all of which have some bearing on the study, therefore should be recorded alongside the more highly charged moments. Tracking methodological

developments and decisions, theoretical insights, the researcher's personal attitude and emotions shed light on the influences that were confronted and problematised the research process (Koch, 1996). These recordings were data for reflection and analysis and therefore incorporated into the research text to illuminate the way interpretation and explanation was achieved.

The use of a reflexive diary and critical incident log (research log) were important research techniques that facilitated dialogue with the self.

Throughout the entire research process an auditable trail was maintained by signposting each step of the research process in a way that allows readers to decide for themselves whether the text is believable or plausible. The dependability of research can be achieved through a process of auditing (Tobin & Begley, 2004). One way of auditing research is through the creation of an audit trail to confirm the research findings (Koch, 1994a). The audit process adopted within this study aims to illustrate that the process of research is logical, traceable and clearly documented (Schwandt, 2001). The audit trail for this study involved incorporating a reflexive account into the research product by signposting to readers what was going on throughout the research process (Lincoln & Guba, 1985). The signposts related to:

- data generated;
- range of literature;
- positioning of this literature;

- positioning of oneself, and
- moral social-political contexts.

According to Koch (1996) if these elements are clearly signposted to the reader they will be able to travel readily through the worlds of the participants and makers of the text and decide for themselves whether the text is believable or plausible.

What follows is a trilogy of chapters presenting the findings of the data analysis. Each chapter discusses the ways health science academics and practitioners (chapters 5), and undergraduate health science students (chapter 6) use language in and about rural health education. Chapter 7 is a discussion chapter that extracts main areas that have implication for rural health education reaching its implicit goal of instilling in students an interest in a rural career.

The chapter reporting academics and practitioners' use of language specifically focuses on three analytic aspects that relates to their role as socialising agents:

- understanding rural health education
- justifications for rural health education, and
- meanings about rural communities.

The chapter reporting students' use of language during the rural placement reports on their lived experience of the socialising process. It discusses

the phases of socialisation through which the students passed. There is particular emphasis on three aspects of this process;

- understanding the rural placement,
- formal purpose of the rural placement, and
- informal purpose of the rural placement.

The discussion chapter isolates and discusses the key findings to emerge from the research. These include;

- drivers for students' adaptation to rural culture,
- structural contexts of rural health education,
  - rural health education as a component of generalist core curriculum,
  - rural health education as a rural workforce strategy,
- academics and health professionals as socialising agents, and
- personal and professional identity as an outcome of the socialising process of rural health education.

## CHAPTER 5 AGENTS OF SOCIALISATION WITHIN NURSING, MEDICAL AND PHARMACY EDUCATION

### INTRODUCTION

The professional socialisation of students is a complicated process in which professions are maintained as intellectual communities through

continuing and evolving discourses. The professional socialisation of future health professionals, as an important subset of this discourse, takes place within the undergraduate schools of nursing, medicine and pharmacy. Academics and health professionals, as 'agents of socialisation' (Kalmus 2006) provide students with many of the beliefs and values that create role expectations. Undergraduate students use these beliefs systems for the planning of their careers. Academics are therefore crucial to the socialisation process in rural health education. It was therefore necessary to investigate how these agents understand rural health education, and talk about rural communities with students.

Two key questions of this research are: (i) how do academic and health professionals understand rural health education as it relates to the broader core curricula of an undergraduate nursing, medical and pharmacy program? And, (ii) how does the day-to-day teaching and learning practice of rural health education construct how rural communities can be known and understood in language? To capture the language used to shape understandings of rural health education curriculum documents were gathered and interviews were conducted with three health science academics and three rural health practitioners. The language used in these texts was analysed using theoretical perspectives of professional socialisation, power and discourse. In the next three sections, the practices that reflect boundary work in rural health education are presented. These include,

- understanding rural health education

- justifications for rural health education, and
- meanings about rural communities.

The findings show that a generalist core curriculum is used to prepare undergraduate nursing, medical and pharmacy students as future health professionals. In these programs, there does not appear to be a body of knowledge known as rural health. Instead, academics and practitioners reconfigure rural health education as a context from which students can professionally develop as generalist health professionals. Furthermore, academics use language of difference and disadvantage in ways that unintentionally constructs rural communities as the medicalised 'other'.

When notions of rural difference and disadvantage are used to prepare students for their rural placement, patterns of language use create a hidden curriculum. It is a curriculum that suggests rural communities are harsh and dangerous places, which implies rural life is an ordeal. The academics attempt to sell rural practice to students by emphasising the positive aspects of rural life, which implies rural life is idyllic. In the rural context, practitioners introduce students to alternative discourses by constructing rural communities as healthy and thriving. Nevertheless, they also unintentionally sustain the hidden curriculum during the students' rural placement. These constructions appear to emerge from a number of possible consequences that relate to the academics and rural health practitioners failure to critically interrogate or unpack rural health education for students. As an entity, rural health education at this

participating university is inadequately conceptualised and this leads to different people making meaning in different ways.

## UNDERSTANDING RURAL HEALTH EDUCATION

This section presents the analysis of the way academics and practitioners understand rural health education.<sup>84</sup> The academics understand rural health education to be a political strategy for responding to the acute health workforce shortages that are currently being experienced in rural Australia. As a rural health workforce strategy, rural health education created tension for the academics who had to find ways of including it in a generalist core curriculum. While it appears they are doing their best to incorporate a rural health component in the undergraduate programs, the academics rely heavily on external guest lecturers and rural health professionals to teach students in this area. The rural health practitioners also understand rural health education as a core component of students preparation as generalist health professionals. At the same time, however, they recognize rural health education as an opportunity to attract students to rural practice.

The undergraduate nursing program at the university under study provides all students with a comprehensive generalist core curriculum. This goal

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<sup>84</sup> The data sources used in this section include the language texts produced from the semi-structured interviews with the academics and rural health practitioners and field notes generated during the periods of observation-of-participation. See chapter 4 for more details about the data sources and methods of data collection and analysis.

is reflected in the curriculum documents for the nursing unit, where the learning objectives state:

1. *Demonstrate a developing knowledge base and skill in pharmacology and medical administration*
2. *Apply acquired knowledge/core nursing skills gained from laboratory participation*
3. *Describe various nursing activities undertaken in practice, self evaluate the experiences, examine their learning needs and identify ANMCI competencies*
4. *Demonstrate a satisfactory performance in practice*
5. *Demonstrate a developed sense of professional responsibility*

*(Nursing Curriculum Document)*

The goal of producing generalist nurses has been advanced since 1986 when nurse education transferred from hospital-based training to the tertiary sector. It is a particular approach to health professional education that prepares students with a broad range of knowledge, experience and skills. Generalist knowledge prepares students for general health service delivery, providing care across the lifespan and in different contexts (National Nursing and Nursing Education Taskforce, 2006). As generalist health professionals provide care for a diversity of people with different health needs, there is now also a growing interest in this style of training for medical and pharmacy students.

Knowledge, skills and attitudes necessary for students to professionally develop as generalist health professionals are embodied in the undergraduate medical and pharmacy curriculum. Once again, this goal is reflected in the learning objectives of the curriculum documents:

1. *Introduce students to the disciplines of paediatrics, obstetrics & gynaecology, psychiatry and general practice.*



2. *Ensure that students have basic skills in history taking and examination relevant to these disciplines.*
3. *Ensure students have an understanding of how factors other than pathophysiology impact upon health and disease. Specifically these are socio-economic status, rurality, and psychological issues.*
4. *Develop skills in communication and evidence-based practice.* (Medical curriculum document)

Generalist health professional education is being put forward by educationalists as a way to respond to societies ever changing health care needs. The current need predominately relates to the way chronic diseases and their risk factors are increasing (Australian Institute of Health and Welfare, 2002). The disciplines of medicine and pharmacy recognise the scale of these emerging health problems cannot be effectively managed effectively by specialist services (vanWeel & Schellevis, 2006). This has seen a shift away from the focus on specialization that has been traditionally valued within these programs. Calls for new models of health service delivery are now well reflected in recent government documents (Australian Health Ministers' Conference, 1999; Australian Health Ministers' Conference, 2003). New models of health service delivery are reliant on education and training that produce health practitioners who can deliver a wide range of skills and training in public health competences to address a number of changing and disparate conditions or issues (Geyman et al., 2000). Most undergraduate medical and pharmacy students are now being prepared to assess a broad range of health problems and manage them in a patient-centred way (Harris & Harris, 2006).

Among other aspects, the generalist core curriculum at the participating university appears to place emphasis on the values of patient-centred

and holistic approaches to health service delivery. These values are reflected in the way the academics expect students to deliver individualized care and take into account the diversity of people and their perspectives, as this interview excerpt demonstrates:

*“... some medical students are peculiarly lacking in any understanding of their fellow human beings and the diversity of human beings . um . and that . that is tremendously unfortunate . enormously unhelpful for them and . desperately unhelpful when they are in hospital and rural community settings but that is being addressed in the curriculum . with the new cohort of students coming through starting next year will have a very much broader understanding of their fellow human beings . we are hoping to prepare students in more patient centered holistic ways so they can respond to a diversity of individuals regardless of where they choose to practice”<sup>85</sup> (MAFI: 3893)*

The term ‘patient-centred medicine’ was originally coined by Balint in 1969 to express the belief that each patient “... has to be understood as a unique human being” (Balint, 1969, p 269). Since then, the concept has evolved and expanded. Today it has become an integral aspect of health service delivery and undergraduate medical and pharmacy education. While nursing education tends to use the term ‘holistic care’, its underlying meaning is similar to patient centredness. In nursing, holistic health care is based on a concept of total patient care that considers the physical, emotional, social, economic, and spiritual needs of individuals (Anderson et al., 1994b). Holistic, and patient-centred approaches to health care emphasises each individual is a unique person with diverse needs. Later in this section, it will be argued that patient centredness and holistic approaches are difficult ideals to attain in rural practice.

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<sup>85</sup> Excerpts have been extracted from the language texts created in this study. In line with critical discourse analysis methodologies, the entire set is characterised by a lack of capitalisation or punctuation, such as exclamation marks. These markings can unwittingly influence the way data is interpreted during periods of analysis.

The recognition that individuals are unique beings reflects the degree of reform that has been achieved in undergraduate programs preparing health professionals for their roles. The health science academics insist that students understand that a patient is an individual to be cared for, and not simply a medical condition to be treated, as shown by this interview excerpt:

*"... the curriculum ... is all about suspending judgement and evaluating your own value system . you know coming to terms with the fact that that's my value system rather than that's the right value system . so the whole thing has shifted . its also about looking at things in a holistic way and looking at difference . looking beyond disease and illness and considering the person as an individual"* (MAFI: 3936)

Traditionally, undergraduate health professional training relied heavily on a biomedical model (Pauli et al., 2000). It was a pedagogical approach that allowed teaching to be organized within behaviourist approaches where objectives were formulated and learning experiences planned to meet them. The move towards more holistic and patient-centred approaches to care has seen education providers embrace a shift to the somato-psycho-socio-semiotic paradigm. This is a pedagogical approach that encourages students to think beyond the physical, psychological and social components of the disease. By recognising people as whole and unique entities, students are encouraged to give greater autonomy and power to people in their health care experiences (Pauli et al., 2000). These changes reflect the way the boundaries of undergraduate curriculum are not static and fixed. Instead, they are renegotiated in accordance with the needs of the wider social and environmental conditions that impact on the role and tasks of health professionals (Engel, 2000).

The undergraduate nursing, medical and pharmacy programs at the university participating in this study have recognized “...there are really bad workforce shortages that urgently need addressing” (PAFI: 3955). It is a need that is explicitly acknowledged in pharmacy curriculum documents:

*“...there is currently a significant maldistribution of pharmacists between urban and rural/regional areas within Australia. The pharmacy profession itself has undertaken various programs to improve recruitment and retention of pharmacists in regional areas”* (Pharmacy Curriculum Document)

In the past, health workforce shortages have been successfully overcome by increasing the overall supply of graduate health professionals. Increasing the supply of graduates has allowed the workforce to be flooded with new recruits. The graduates quickly develop knowledge, skills and experience in their new areas of employment and become valuable team members. Increasing the supply of graduate health professionals is an approach the Commonwealth government has already begun to implement. The Commonwealth government has recently made available funds to support an additional 4800 nursing, and 3600 allied health students’ university places by 2008. It is also seeking to increase the number of medical students by 30% by 2009. This may be a significant step in addressing the general health workforce shortages. As a single approach, it is not expected to address the rural health workforce shortages (Humphreys 2007) that have now reached crisis point.

The ongoing health workforce shortages, across all disciplines and in all locations, are one of the broader conditions to which undergraduate education is currently responding. The academics were well aware of their

responsibility in this area and recognised the generalist core curriculum as a way of preparing large numbers of students for their roles in any health context, as the following interview excerpt shows:

*"... everything we teach in this unit is generic, while there may be other content that the students encounter this is really just secondary and not the main focus of their learning . we have to think of all areas in nursing . there are workforce shortages right across the board . so we can't just focus on one of these . anyway students make their own decisions about where they want to work "* (NAFI: 3800)

There is already evidence that the current number of education and training places in the higher education system will be insufficient for addressing the current rural health workforce shortages (Productivity Commission, 2005b). It takes between four to ten years for students to move through their education and become established as health professionals. Steadily increasing the supply of graduates over the next two years will therefore do little to address the shortages across all health disciplines in rural areas. Many rural communities are already struggling to provide health services. This is of particular concern because the rural health workforce shortages are expected to worsen over the next decade (Productivity Commission, 2005a). Even if the supply of graduates could be increased in the short term, research from other countries indicates there are no guarantees graduates will want to work in rural areas (Pathman, 1996). It is a trend that is likely to recur in Australia because it is known that graduating students tend to work in urban areas (Humphreys, 2007). Thus, there is a risk that by simply increasing the number of student enrolments, greater numbers of graduate health professionals will be seeking employment in urban Australia. It

is this imbalance in the geographic distribution of health professionals that rural health workforce policy is seeking to redress, not create.

Attracting students to rural practice is contingent on a multileveled strategy that incorporates best practice models of rural health education. The following extract from the analysed curriculum documents for the undergraduate nursing, medical and pharmacy programs show there have been some attempts to increase the rural health component in the academic units:

*“...there is a session that uses the same cases that were presented in week 5 [menstrual problems, infertility, and disorders in early pregnancy], however, discussion will revolve around the patient’s context, rather than just clinical issues. How does the patient’s socio-economic status affect how health care is experienced and provided. [sic] How does a rural or remote location affect the practice of medicine and the patient’s experience of health care? How is the health status of a rural community different from a metropolitan one?”* (Medical Curriculum

Document)

In the academic context, isolated incidences of rural health component appear to be incorporated into the prescribed generalist core curriculum primarily using problem-or case-based learning. These approaches to teaching and learning use contextual problems as the basis of student’s knowledge acquisition rather than the concept of a disease process (Finucane et al., 1998). It is a pedagogical approach that invites students to consider the whole bio-psycho-social nature of individual’s experience of health or illness. The emphasis is on facilitating student’s critical reasoning and problem solving abilities rather than simply arming them with facts to be rote learned (Finucane et al., 1998). Although these teaching and learning activities are an effective and important way for students to learn about rural health in a contextual way (VanLeit & Cuba,

2005), these appear to be isolated attempts to include rural health content.

There has been a diversity of responses to the need to include rural health content in the undergraduate generalist core curriculum at the university participating in this study. This ranged from an insistence that “... *everything we teach in this unit is generic*” (NAFI: 3800) through to “... *I am trying really hard to accommodate the rural program in this unit*” (MAFI: 3869). On the whole the academics appear to be doing their best to include some rural health content, in some form or another, in their units. Overall, however, it seems that academics must resort to juggling the existing generalist core curriculum to incorporate a rural dimension, as the following interview excerpt shows:

*“...I do health promotion and try to give it a rural slant . I tell them how rural populations have a poorer health status and talk about all the reasons why that might be occurring . lifestyle issues . low socio-economic status . education levels are pretty low . that sort of thing . high use of drugs and alcohol . I try and get the students to think about how pharmacists can help people improve their health rather than just concentrate on dispensing scripts”* <sup>86</sup>(PAFI: 3976)

Such adaptive strategies are testament to the academics active agency playing a role in the way they can negotiate and renegotiate the boundary of the pedagogical space to include rural health education. It is source of power that enables rural health education to be advanced in the undergraduate nursing, medical and pharmacy programs. At the same time, however, these processes of teaching and learning are vulnerable. They are unlikely to be sustained should staffing patterns change or Commonwealth funding ceases to be available. Such

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<sup>86</sup> This interview excerpt is also an example of the discourse of rural difference and disadvantage that is so ingrained in the rural health education literature. Further examples of this use of language in rural health education are presented and discussed in the later parts of this chapter.

heavy reliance on temporary structures for the design and implementation of rural health education poses a real threat to its sustainability in health science education.

The academics recognise the need to incorporate rural health content in the undergraduate curricula and seem willing to accommodate this. Despite some attempts to incorporate rural health content into their teaching, they appear to be working from an uninformed position in this area. The following interview excerpt demonstrates the academics uncertainty with the rural health content area:

*"...part of my role is to try and increase the rural curricula in the school ... nobody really knows what rural curricula is . so they are still trying to sort that little one out "* (PAFI: 4052)

*"... my familiarity with the rural health component was fairly modest . and I have had to work reasonably fast to catch up ... but if we are to continue to send these people to a rural context we need to give them more information about the opportunities that are available to them"* (MAFI: 3924)

For academics who are interested in incorporating rural health content into their programs, it is difficult for them to access information and resources to assist them with this task. There is information in the published literature (c.f Hays, 1990; Hays, 1992; Hays, 2001a; Hays, 2001b; Hays, 2002a; Hays, 2003; Hays, 2005; Murphy et al., 1994; WA Health Department, 1987; Worley & Lines, 1999; Worley et al., 2004b; Worley et al., 2000; Worley et al., 2004c) relating to existing rural health courses. There is also a body of literature that discusses the technical aspects of designing and delivering rural health education (Hays, 1990; Hays, 1992; Hays, 2001a; Hays, 2001b; Hays, 2003; Hays, 2005). There is less



work being published on the concepts and constructs that might be beneficial for educators to incorporate into rural health curriculum design at the undergraduate level (c.f Bourke et al, 2004). One possible reason for this may be that rural health is only now beginning to establish itself as a distinct discipline. While there has been some work done in this area at the postgraduate level<sup>87</sup> (Trumble, 2003) there is an urgent need to test the appropriateness of using these resources at the undergraduate level. There is also an urgent need for detailed, research-based and theoretically informed work to assist educators with rural health curriculum design and implementation in undergraduate nursing, medical and pharmacy programs. At present the literature primarily deals with the broad topic of rural health. It does not clearly identify the specifics of what a rural health professional is, what they need to know and how they can best learn<sup>88</sup>.

Without an adequate knowledge base, or access to information, about rural health the academics appear to be uncomfortable with the responsibility for teaching students about rural health. As the following interview excerpt shows, they seem to defer most of the responsibility for teaching such content to guest lecturers who are external to their schools:

*“... part of the [ ] program does include a session with [ ] who actually gets students to look at cases they have seen and presented cough and focus very strongly on the rural implications in the case . um . and it certainly crops up all the*

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<sup>87</sup> For instance, the peak professional organisation for rural medical education and training in Australia has developed a number of rural education and training programs for doctors.

<sup>88</sup> See chapter 2 for an indepth discussion of the gaps in rural health education knowledge.

*time when students present their cases . that you know I saw this lady in rural practice whereas in [city place] she may have gone for an ultrasound . that isn't what happened in [remote place] or wherever . I guess that's as much as I can say about that"* (MAFI: 3869)

The importance of having faculty staff members who are familiar with rural practice and rural life is emphasised in the rural health education literature (Hays, 2006). Inviting external guest lecturers to deliver lectures about rural health to students is therefore an effective way of including it in the undergraduate programs. Once again, these appear to be isolated instances of rural health curricula delivery. If the academics do not engage with rural health content, they will remain uninformed about the issues, problems rural communities are facing. Nor will they become familiar with the opportunities that are available to students in rural areas.

The academics were interested in learning more about the rural health content that was being delivered to the students by the external guest lecturers, as this excerpt shows:

*"... they [the students] also have other lectures about the statistics of health in rural area . and that comes in by lectures with [name] which they do with medical students . but essentially that is a big black hole because no one can actually find out what he does"* (PAFI: 3979)

The academics are divorced from the meanings that are being constructed about rural communities in the didactic lectures. Nevertheless, through their absence the academics uncritically accept these meanings. In doing so, there is little evidence of opportunities for academics to engage students in a process of critical reflection for analysing, reconsidering and questioning the way rural

communities are being constructed. A critical reflective approach gives greater meaning to the position of the learner in the educational process (Higgs et al., 2001). By failing to examine or critique these social constructions with students, the academics instead unwittingly imbue them with authority. More research is required to describe and analyse the meanings that are being constructed by external guest lecturers. Without knowing what students are being told and how rural communities are being represented in these forums, rural health education will continue to occupy a marginal position in the undergraduate nursing, medical and pharmacy programs at the participating university. It is position in which the academics not only rely on external guest lecturers, but also health professionals to inform students about rural health during rural placements.

All schools of nursing, medicine and pharmacy are mandated by their registering authorities to provide students with a prescribed amount of opportunities to learn through experiences in a variety of health care contexts and situations. In recent years these clinical practice rotations have extended to include rural areas. The following interview excerpt illustrates the way the academics recognise rural health professionals as expert practitioners and therefore regard them as qualified teachers for delivering rural health content to the students:

*“... most of my friends work in rural and remote areas so they tell me how I should do my job . so they say [name] you trying to show me how to suck eggs . why don't you focus on the preparation of the students and leave the rest to us . they now what rural is about more so than me . they can teach students more about rural health than me . I think what I now realise is that most of the registered nurses in rural and remote areas have far more certificates than I am ever going to have .*

*they have far more experience in a diverse array of patient behaviors than maybe we are ever going to see so I tend to leave it up to them” (NAFI: 3806).*

From this excerpt it can be seen the academics tended to conflate rural health content with students learning about aspects of professional practice. This suggests that within the undergraduate nursing, medical and pharmacy programs at the participating university, the body of knowledge that defines rural health is obscured or dominated by generalist curriculum considerations. Clinical learning opportunities have always been a feature of undergraduate health science education. These practice-based activities allow students to experience the complexity of the social, cultural and tacit nature of professional knowledge (Knowles, 1985; Knowles, 1998; Kolb, 1984; Schon, 1983, 1991). Such professional knowledge is best learned and acquired through ‘situated’ (Lave & Wenger, 1991) and ‘experiential’ (Kolb, 1984) learning where students “... construct meaning out of their experience” (Kolb, 1984). Additional to these clinical learning opportunities, the academics assume the rural placements to be a form of “place-based education”. This is an educational approach that attends in explicit ways to features of the social environments of rural places. However, this assumption does not appear to be communicated to rural health practitioners therefore the boundaries of the pedagogical space for rural health education seem to be highly flexible.

The flexible boundary allowed the pedagogical space to be changed by the rural health practitioners to reflect their own cultural values and traditions. As the following interview excerpt shows, the practitioners

understand rural health education as a core component of the professional development of students as emerging health professionals:

*“... the [students] are here to develop a lot of their clinical skills from us . . . its handy to know where the students are up to in their course . what they can and can't do . if we know this we can organise for them to experience certain things . they generally need help with their time management skills . organisational skills and prioritising . . . because we are the grass roots . they [academics] can't teach a lot of the time management . so they rely on us I think to do that . the practice dimension” (RNFI: 4235)*

Learning in clinical and professional settings allows students to confront real life challenges that are absent from the classroom (Windsor 1987). The role practitioners' play in supporting students with this learning in action makes them key agents of socialisation<sup>89</sup>. By demarcating what knowledge and actions are important for students to learn in the professional context, practitioners are able to claim authority over a situation. In this position of authority, they are able to collect on the attendant benefits of having students in their health care agencies.

In this study, the rural health practitioners used boundary work as a way of constructing the rural placement to secure their own interests. The following interview excerpt shows how the practitioners recognise the rural placement as an opportunity to attract students to rural practice:

*“... the idea of starting it was ... the best way to get . to address the shortage of . . of health professionals long term . not just pharmacists . but the best way to address the shortage in rural communities ... was to give [students] a taste of coming out here ... to give kids the exposure of living in country life .and [I] always thought . right from when I was first talking with [name] that if you got*

<sup>89</sup> The concept of 'agents of socialisation' is discussed on pages [643](#) and [1643](#).

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*them out here . show them there are lots of advantages to practice in rural community . they might come back” (PHFI: 4095)*

Rural health professionals are at the forefront of the workforce shortages. They must deal with the day-to-day reality of working long hours, and delivering health care that may be beyond their level of expertise or scope of practice. Some nurses are reportedly taking on responsibilities and practices in the absence of medical doctors to maintain health services in many rural and remote areas (Hegney & Hobbs, 1998). It has also been found (Hays, 2007) that rural doctors are frequently required to perform procedures and provide care to patients that in a metropolitan area would typically fall in the domain of a specialist. Many rural health professionals are overworked and report difficulties in organising locum relief to cover them for holidays or attendance at professional development activities (McDonald et al., 2002). The opportunity to attract future health professionals to rural practice was therefore taken up as a justifiable use of time.

## JUSTIFICATIONS FOR RURAL HEALTH EDUCATION

Academic staff and rural health practitioners are typically busy people with little spare time on their hands. Any activities they devote their time, energy and expertise to must be well justified. This section analyses the way academics and practitioners justified their contributions to teaching and learning in rural health education. These academics were highly committed to producing generalist health professionals for graduation. They constructed rural health education as another professional learning context. This allowed the

academics to justify rural health education as another way for students to learn and acquire generic knowledge and skills. The rural placement was particularly valued for the opportunities it provides students to professionally develop in actual health care agencies. The practitioners shared the academics objective to socialise students into the realities of professional practice. Despite working in contexts that are frequently under staffed and under resourced they agree to accept students. The possibility that students may return to their rural community as future practitioners was sufficient enough for the practitioners to justify their teaching contributions.

The academics in this study, understood their purpose for engaging with students to be the production of generalist health professionals. As the following interview excerpt shows, they not only anticipated that students should learn and acquire generalist knowledge, skills and attitudes, but they also expected students to achieve a beginning level of competence:

*“... we sign their registration off every year to say they are competent so therefore we take what they say very carefully ... so we look at the ANMC competencies very carefully to the letter and when an issue arises you just point it out and say according to this you’re not competent and therefore or you’re not satisfactory or unsatisfactory therefore we need to work on that . so we follow everything to the T”*

(NAFI: 3851)

It is possible for students to practice their skills and learn theoretical knowledge, which Polyani (1962) referred to as “knowing that”, in the classroom setting. Competence, however, is more than students achieving skill mastery and building a comprehensive knowledge base. It is the ability to engage in a process of clinical reasoning and apply their knowledge to the unpredictable

and dynamic situations that present in the professional context. Competent practice knowledge, which Polyani (1962) referred to as “knowing how”, can only be developed over time as students become proficient with the theory-practice nexus. The development of such clinical and professional competence requires students to spend time learning in actual health care agencies. Since the numbers of undergraduate nursing, medical and pharmacy students have been increasing, opportunities for students to undertake clinical learning experiences in professional settings have become more difficult. The opportunity for students to undertake their clinical practice rotations in rural health care agencies was therefore an attractive arrangement for the academics.

Within the field of rural health, educationalists and researchers consider rural placement to be the key learning experience for generating student’s interest in rural practice as a future career option<sup>90</sup>. As the following interview excerpt shows, rural workforce recruitment was not the primary concern for the academics in this study. Instead, they constructed the rural placement as another learning context for students to develop as generalist health professionals:

*“... people are people whatever environment they live in . you can’t tell me that people that live in [regional place] who have cardiac disease and someone in [remote place] doesn’t . so people get sick everywhere . it’s about being inclusive . we wanted to include rural as a learning context for the students . the experience of being a nurse and providing care is generic . whether you are in the country or in the city or living on a small island” (NAFI: 3793)*

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<sup>90</sup> Please refer to chapter 2 for more details on ways rural health education has been constructed as a rural health workforce supply strategy.



The central argument being constructed by this academic is the experience of health and illness, and conduct of professional practice does not change according to place. People who live in rural areas do reportedly (Dade-Smith, 2004; Dade-Smith, 2007) experience health problems differently because of the difficulty they have accessing health care services. Furthermore, professional isolation, workforce shortages, and the multi-skilled nature of care does reportedly make rural practice unique (McDonald et al., 2002). The academics appear to be unaware of these attributes of health, illness and practice in the rural context. Instead, the account of the rural placement as a generic learning context draws attention to the ways students are expected to learn from and respond to peoples malfunctioning body parts. It is a biomedical view of health, illness and practice. It is a view that allowed the academics to concentrate on the generic learning opportunities for students to develop as generalist health professionals, regardless of the context.

There is some recognition by the academics of the knowledge, skills and attitudes requisite of rural practice to be distinct and specialised<sup>91</sup>. The following interview excerpt shows how rural health education, constructed as a distinct body of knowledge, made it difficult for the academics to justify the inclusion of rural health content in the generalist core curriculum:

*“...it all stays generic . otherwise we would have to run a whole subject on acute care, community care , aged care . I mean we just can’t do that . I mean the [place] is rural . so . anything they learn about rural health comes from the clinical*

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<sup>91</sup> There were only three academics participating in this study. It is worth noting, however, these academics were the unit coordinators and therefore influence the way other tutoring staff in these units think and act.

*practice experience . we just can't include anything about what it's like in a rural community"* (NAFI: 3822)

The field of rural health has been trying to establish itself as a distinct discipline for some time now (Dade-Smith & Hays, 2004; Strasser, 1995). Some commentators (Dade-Smith, 2004) argue there is 'not a lot' of difference between the practice of health professionals in rural and remote settings. Others (Lian, 2007, Thurston & Meadows, 2003) have been trying to understand the nature of rural practice, as if health care practice varies according to place. One key area of differentiation that has been isolated relates to the rural context itself (Duffy et al., 1998; Wilkinson & Blue, 2002). Environmental harshness, and social and professional isolation requires health professionals to practice at more advanced level in the rural setting (Dade-Smith, 2004; Keyzer, 1995). Constructing rural health as a distinct discipline has been necessary for the field to gain recognition, attract scarce resources, and raise awareness about the difficulties rural communities have been experiencing accessing health care services. As a specialised field of knowledge and practice it challenges the way the academics can assimilate rural health education within the generalist curriculum.

By arguing the rural placement is a generic learning context the academics used boundary work to construct ideologies that serve the institutional interest of producing generalist health professionals. The following interview excerpt shows how the academics placed a high degree of value on the generalist learning opportunities the rural placement makes available to students:

*“...well I suppose the good thing about rural placement . they way I perceive it . having never done it . is that it is an opportunity to work with doctors and real people with real problems without the capacity to refer on and the like and it gives the students the opportunity to see the continuity of medical care you know they often see patients who are very well known to the doctor ... I think that rural medicine tends to offer a context for people to . actually see this episode as part of the ongoing life of that person” (MAFI: 3877)*

By narrowly constructing the rural placement as a context from which students can learn, the academics never individually define rural health as a body of knowledge. This may have serious consequences for the instrumentalisation of rural health education. The academics do not appear to embrace a sense of commitment to encouraging students to learn about the unique features of rural practice. Instead, they legitimise the rural placement in a way that serves a different purpose than attracting students to the rural health workforce. Boundary work is accomplished through constructing a less highly valued objective around which a boundary can be drawn and differentiation made (Gieryn 1983). For the academics, it was a boundary that defined the pedagogical space for rural health education as a generic learning experience rather than a rural learning experience. As such, it appears there are no opportunities for students to share, discuss or critically interrogate their rural learning experiences. The absence of these academically facilitated opportunities means students may be left alone to formulate their own interpretations and meanings about living and working in a rural community.

Research shows (Hays & SenGupta, 2003; Mischler, 1986; Wentworth, 1980) that context always has some influence on student’s learning

experiences. Even though the academics did not consider the rural dimensions to be the most valuable aspect of the rural placement they were aware these contextual aspects may generate student's interest in a rural health career, as the following interview demonstrates:

*"...depending on the context um . it will influence the students learning and we have found obviously that students .whatever the context . if they are in supportive environments they learn in leaps and bounds . so just by being in the rural context they might become interested in rural practice . but we don't actively engage in teaching about rural in this unit . they learn this as an added extra from their experience" (NAFI: 3800)*

Including the rural placement in the undergraduate nursing, medical and pharmacy programs not only allows the academics to provide greater numbers of students with clinical learning opportunities. It also allows them to justify their contributions to generating student's interest in a rural career in ways that meet the Australian Government's criteria for ongoing funding. By arguing that 'just being' in the rural context might attract students to rural practice, the foregoing analysis has functionalist overtones<sup>92</sup>. The academics seemed to regard the rural placement as a powerful structural reality through which students could be socialised into ways that might be conducive to generating their interest in a rural career. Functionalists believe that behaviour is structural and social rules and regulations help organised the relationships between members of particular groups (Denzin & Lincoln, 2006). It is a view that down plays the role of student agency in career planning. At the same time, however, the absence of a well

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<sup>92</sup> The functionalist account of socialisation was outlined on page [1453](#).

developed rural health curriculum means the academics must rely heavily on student agency to drive learning during the rural placement.

In order to make decisions related to career planning options, students must first distinguish features that are attractive for working in a particular field, or geographic location. The following interview excerpt shows the academics assumed the students would assess rural practice as a possible career option by comparing it to urban practice:

*“...they’re not only mixing with other students but they are seeing what health professionals do . and that doesn’t happen anywhere else in the course . so they can actually see the difference between a rural health professional and a metropolitan health professional because it is nowhere else in the course” (PAFI: 3955)*

With no rural health curriculum or academically facilitated interaction during the rural placement, students are forced to rely upon their own background experiences to assess the differences between rural and urban practice. Bourke et al (2004) argue the rural placement alone is insufficient for students to gain a deep understanding of such differences. It is an argument that can be further extended. Perhaps the lack of academic teaching support for students during rural placement limits opportunities for them to critically analyse the knowledge and truth claims being produced about rural people and practice. Power theorists (Foucault 1977, Fairclough 1995) have shown that when meanings about groups of people are constructed against naturalised and taken-for-granted assumptions they can maintain asymmetrical power relations. This is because when individuals make assessments about another group through a process of comparison, they tend to hold their own group in higher authority.

With the majority of health science education taking place in metropolitan settings, researchers (Hays, 2001a; Hays, 2003; Hays, 2005) argue urban perspective is privileged. This is of particular concern because individuals tend to be attracted to organisations with which they have attributes in common (Schneider, 1987). It was this taken-for-granted urban perspective the rural health practitioners found most challenging during the rural placement.

Earlier in this chapter it was argued the academics rely heavily on health professionals teaching contributions in the undergraduate nursing, medical and pharmacy programs at the participating university. The academics not only expect rural health practitioners to socialise students into their professional roles but also teach them about rural health. Teaching is an integral component of a clinician's role. As the following interview excerpt shows, the practitioners understood their purpose for engaging with students as an extension of this component of their role as clinicians:

*"I think [we] are helping them in their education and ...to get some experience and develop some skills . I see that as part of what we should be doing as nurses anyway . plus just by being here they also get to learn about rural . and they just may come back . [name's] attitude was for us to get the graduate nurses in and teach them as much as we possibly could . but if they didn't want to stay [name] didn't want to educate them . but I didn't see it from that point of view . I see it that it really didn't matter if they didn't stay in our area. It was for nursing and I mean what is our loss is somebody else gain"* (RNFI: 4268-4270)

The practitioners saw the rural placement as an opportunity to assist students to learn how to fit into the culture of professional practice in a generic way. The expectation that clinical practice allows students to experience a process of socialisation into the professional culture is widely acknowledged in

the health science education literature (Edwards et al., 2004; Leigh et al., 2004).

Short term clinical practice opportunities are known to help students familiarise with the realities of practice (Chater, 1999). At the same time, the demands of the workplace often mean that students have insufficient time to be fully exposed to social rules (discourses) that govern the professional organisation of work (Carlisle et al 1999). This may explain why the practitioners drew boundaries around two key areas they considered important for the students to learn during the rural placement. These included, socialising students into the realities of practice and immersing students into rural culture.

According to the practitioners in this study, the academic context prepares student with theoretical knowledge and grounding in basic skills. The following interview excerpt shows how, as experts, they considered it their role to teach students how to organise this knowledge in a more sophisticated way.

*"...they're here to develop a lot of their clinical skills from us . we watch how they go with time management skills . organisational skills and prioritising . I mean the university do a lot of it . um academic study. But as far as the clinical teaching goes .and I mean they probably do a lot of the clinical teaching as well . um . because we are the grass roots , they can't teach a lot of the time management . a lot of professional knowledge is learned by trial and error, by reflecting on past experiences ' theory is important but I believe the most important aspects of learning come from being with experienced clinicians – by having students observe them and then taking part more and more in practice under supervision. so they rely on us I think to do that . the practice dimension"* (NAFI: 4234)

The expert knowledge that professionals use but find difficult to articulate is known as tacit knowledge (Polanyi, 1966). The practitioners recognised that students need to learn this tacit knowledge to participate in professional practice activities in preparation for their future roles. As such, the

practitioners considered it important the students gained the skills and knowledge necessary to accept the accountability for their actions in health service delivery. Prior to the mid-1980s student nurse training was structured within an apprenticeship system within teaching hospitals. The views expressed by this practitioner could be indicative of this apprenticeship approach to teaching and learning, where 'students are initiated into their roles by experts' (Jacka & Lewin 1987). It is a view that has implication for rural health curriculum development and preceptor<sup>93</sup> education programs. It appears the educational process during the rural placement is not focusing on developing abilities as student health professionals, but rather as developing students as future qualified health professionals. These are not necessarily the same.

In an apprenticeship model of clinical teaching students learning experiences come second to the needs of the socialising organisation. In rural health care agencies, which are typically understaffed and struggling to provide health care services to a diverse population with a myriad of needs, the organisational focus is often on getting the work done. The following interview excerpt shows how the practitioners were adamant that students should gain some understandings of the realities of working as a busy health professional:

*"... you know these guys are really in for a shock . they need to get with the program . get to know what it is like in the real world . I just really wanted to stress to them what it is really like here . there are times when I am so busy . I can barely get around all of the patients most basic needs . let alone spend quality time*

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<sup>93</sup> Preceptor is a term being used to refer to health professionals who contribute to the supervision of undergraduate health science students in the professional settings. Other terms that can be used to describe this include clinical supervisors, clinical educators, mentors, and clinical facilitators.



*with them . when its like that I just have to forget the students and get on with what I am doing . part of working here is learning to keep up” (GPF1: 4164)*

There are many aspects that challenge the education of undergraduate students in the professional context. One in particular pertains to the tension that arises when health professionals are forced to juggle the dual demands of teaching and meet the demands of a busy workplace (Bowman, 2001; Walters et al., 2005). Some researchers (Hodgels 1997) identify that during these busy periods practitioners tend to approach professional practice in a technocratic and scientific way. It is a temporary approach to practice that abandons the ‘patient-centred’ or ‘holistic’ view of health care in favour of getting through busy periods. In these instances, students have been found to be exposed to the more bureaucratic culture and values of professional practice (Moorhouse, 1992) where they tend to be socialised into the more task-oriented approaches to health service delivery.

An undergraduate nursing, medical and pharmacy student cannot be expected to learn and practice in the same way as an experienced health professional. Despite this, the following interview excerpt shows how the practitioners expected the students to adopt a dual role of worker and student during the rural placement:

*“... yeah look it’s pretty crazy here that’s for sure . but I really believe it is important for the students to come and work here for a bit . I mean I can busy them with various things around the pharmacy . once they get the hang of dispensing and the like it’s easier because I can get them doing that stuff while I get on with other things” (PHF1: 4101)*

It is argued that undergraduate students should assume a supernumerary status during clinical practice rotations to avoid their socialisation to meet the service needs of the organisation (Higgs et al., 2001). Students are in a transition phase of their professional development (Benner 1984). They should be *learning* how to care for patients and organise aspects of practice (Infante et al., 1989). They are not ready to assume responsibility for *caring* for patients (Infante et al., 1989) or wholly participating in professional practice until they reach graduation. It is now recognised that students' educational needs must always supersede the service needs of the health care agency as best practice models for them to develop as health professionals. The difficulty with placing students in rural health care agencies for clinical practice experiences relates to the constantly busy culture of rural practice.

The rural health workforce shortages are now reaching crisis point. It is well documented that rural health professionals are overburdened and struggling to provide health care services for their communities. The following interview excerpt shows the practitioners in this study were desperate to recruit new graduates to rural practice to alleviate this situation:

*"... look I know the nurses are busy . but I just think we have to keep taking students . we just are so desperate for them to come back and work here"* (RNFI: 4276)

The possibility that students may return to the rural context to work as future health professionals allowed the practitioners to justify the time, energy and expertise they dedicate to clinical supervision. These experiences are conducive to students developing and working toward mastering their generic

clinical skills. At the same time, however, the extremely busy nature of the rural health context means students were predominately exposed to the values of the 'traditional, reductionist and scientific view' (Rolfe et al., 1995) of health service delivery. As such, the values that appeared to prevail in the resulting technical-rational context conflicted with the way students were being taught about 'holistic' and 'patient-centred' care in the academic context<sup>94</sup>. Sometimes, the practitioners were so busy students were left behind or given tasks to occupy their time.

One way the health professionals alleviated the intense demands associated with the clinical supervision in the rural setting was to share the load with other health professionals. The following interview excerpt shows how one rural health practitioner spoke about the need to have a break from students:

*"...I send the students up to work for half a day with the doctors . another day with the community nurses . time in the nursing home . I like the students to get interprofessional experience . its gives me a break . sometimes it's really hard to give the students the time they deserve . plus it is a way of getting them out in the community"* (PAFI: 4133)

One way the practitioner manages to ease the additional workload created by students undertaking rural placements, is to extend their clinical learning experiences to include time in different health care contexts. The justification for including this aspect of the rural placement is for students to learn about rural practice from different disciplinary perspectives. The health care needs of society are changing. This is changing the landscape of health service delivery and the

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<sup>94</sup> The implications of this finding for rural health education as a component of the generalist core curriculum are discussed in more detail in chapter 7.

training of undergraduate nursing, medical and pharmacy students. The need for health professionals to work together, rather than implement care in the traditional silo approach, is now being advocated by professional bodies and education institutions. While the need for individuals to learn together is a relatively new concept at the educational level, the nature of working in the rural context has always demanded teamwork and collaboration (McNair et al., 2001).

In order to function as effective health professionals, rural practitioners cannot simply focus on the dimensions of clinical practice. In order to provide holistic care, that extends beyond the need to treat illness to promote health, rural health professionals are forced to consider the social dimensions of their community. As the following interview excerpt shows, it was this seamless link between practice and community that the practitioners considered important for students to learn about:

*"... we actually do a fair bit of social stuff with them . you know we made sure we had a night out with them . um we took em to the service club . the service clubs tend to be a pretty important part of the communities in the rural towns . and professional people . when they do move to any rural community . are pretty quickly invited to be part of that group to be part of it . I would like to do more with them but I can't legally leave the pharmacy . I arrange for the girls to take them on tours and the like and in pharmacy in particular"* (PAFT: 4097)

Perhaps this was one reason why some of the practitioners in this study insisted the students spend as much time in the rural community setting as in the health care agencies. Research on socialisation emphasises the importance of students having their roles defined (Thornton & Nardi, 1975). To accomplish this task, it is important that students acquire information about what others consider

important (Weidman, 1989b). It is also necessary for them to learn about the prevailing norms and values of that culture (Clouder, 2003b). Rather than making these norms and values explicit to the students, the practitioners preferred to immerse the students into the day-to-day events of rural life. From these experiences the practitioners expect the students to learn the normative information, or information that is highly valued in rural practice. Some rural health commentators argue “... *the opportunity to acculturate students into the rural lifestyle is lost when students placements are insufficiently long for them to put down roots in the community and to understand how to ‘live’ there more broadly*” (Denz-Penhey 2004, p 2).

Making connections and interacting with people in the rural community was recognised as a crucial way for the students to learn about rural life. Establishing and building social relationships take time. The following excerpt shows how the health professionals tried to expedite such relationship building for the students.

*“... I know that other preceptors have tried really hard to have people . you know I had them come to my house for tea . and . do different things . go to meetings . you know the rotary . you know . do house calls all that stuff . that gives them more of a picture of what it is like in the community . we really would like them to come back one day”* (MAFI: 4166)

The strong connection between rural practice and the rural community can be understood as normative information, or information the health professionals expect the students to acknowledge and/or accept. These activities were designed to give students a snapshot of what life is like in the rural community. It is an

orchestrated form of socialisation in which the practitioners expect students to learn about the norms, beliefs and values of rural life and internalise them as their own. It differs from the functionalist approach in which the academics assume students will acquire an interest in rural practice by just being in the rural context. Instead, the practitioners acknowledge the students active sense of agency and assume a more interpretative approach to the socialisation process. It is an approach in which the health professionals acknowledged the way students form meanings from their community immersion experiences. They were well aware the students would base their decisions about rural intentionality on these meanings.

## MEANINGS ABOUT RURAL COMMUNITIES

Within the study setting, the boundary of the pedagogical space for rural health education was constructed in different ways by different groups in different contexts. The academics construct rural health education as another learning experience for students to develop as generalist health professionals. While the rural health practitioners share this view, they also regard the rural placement as an opportunity to attract students to rural practice. Each of these groups brought different beliefs and values to the pedagogical space for rural health education. These ideologies influence the way particular meanings about rural communities are constructed in their use of language. The task of this section is to analyse how different patterns of language use worked to construct rural communities in the pedagogical space for rural health education.

The shared mission of the undergraduate nursing, medical and pharmacy schools at the participating university is to produce competent and adaptable health professionals who are well equipped for their future roles. It is logical then, that a great deal of time in the curriculum involves academics using medical language to talk about curriculum content with students, as illustrated by the following interview excerpt:

*“... we adopt a case study approach where we may look at the care of anybody whether it be a patient with respiratory illness or anybody with a cardiac illness wherever they may be and each week we look at a different case study . so it may be a young guy who has fallen off a ladder with a head injury and we look at how to take neurological observations and the care of someone with neurological deficit” (*

*NAFI: 3765)*

As the previous sections showed, the undergraduate nursing, medical and pharmacy programs at the participating university rely on a bio-psycho-social curriculum. It is a model that acknowledges the social and environmental conditions that impact upon an individual's experience of health and illness. An additional component of this model is the biomedical perspective. This is predominately concerned with disease and illness caused by biological forces (Rose & Best, 2005). By constructing the body in this mechanistic way it is possible to understand the interrelation of the various components that make up human life at the cellular level. These understandings are important for students to know in order to recognise the signs of dysfunction in the body (Turner, 1987; Turner, 1992). At the same time, it is important to question the role of this heavy use of medical language in Western society.

The use of medical language in educational programs preparing nurses, doctors and pharmacists seems perfectly logical. Sometimes, however, these understandings can become so embedded in belief systems that its dominant values are no longer questioned. For instance, the academics use of medical language was not only restricted to describing phenomena at the level of the individual, but was also used to talk about rural people at the social level, as shown by the following interview excerpt:

*"...each week we look at a different case study ... we go into aged care where someone has had a stroke or consider how disease processes such . as dementia . might be caused by the ageing process or it might apply to a student going to a rural or remote area where they actually come across someone who might be depressed due to living in that environment so we look at it as emergency nursing and in terms of the first 24 hours or we look at it 20 years later if someone who has had a stroke in an aged care facility"* (NAFI:3765)

In this excerpt the academic applies medical understandings not only to the diseased or injured body at the level of the individual, but also to other non medical aspects. In the former excerpt, the very normal experience of living in a rural area is associated with the medical condition of depression. When non medical problems become defined and understood as medical problems they become medicalised. Conrad (2000, p 322) defines this as a process of "... defining a non-medical problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat it'".

Sometimes the academics defined and understood whole populations, their life experiences and other social phenomena within this medical framework. For instance, one academic stated "...rural people have more heart disease than metropolitan . the communities are sicker . it's expected to get worse because



*of the workforce shortages” (PAFI: 3987).* By doing so, problems in social life become medicalised.

When problems in rural social life come under the medical gaze and become colonised by the medical profession, the capacity for understanding rural populations as normal and healthy communities is diminished. The following interview excerpt shows there is a conspicuous absence of language defining rural and remote populations or communities as normal and healthy in the undergraduate nursing, medical and pharmacy programs:

*“...its looking at community differences . accessibility to services and that sort of thing . not dwelling on the fact that rural people have more heart disease than metropolitan but acknowledging it. the communities are sicker . its expected to get worse because of the workforce shortages” (PAFI: 3987)*

According to Moriarty et al (2003), rural Australia has been conceptualised within a pathological discourse that conceives rural communities through images of death and disease. These commonly manifest as “...the terminal decline of our rural communities”, “... the dead hand of drought”, and “... the peril of youth suicide in rural areas” (p 135). These types of constructions are disabling discourses that psychopathologise rural life (Moriarty et al., 2003). By constraining talk to notions of poor health, and limited access to and accessibility of health services, rural experiences are predominately configured within limiting modes of being. According to Moriarity et al (2003), this portrays a ‘deficit model’ for understanding rural communities. These deficit understandings underpin constructions of non-metropolitan Australians as less

normal and more in need of support and intervention than their metropolitan counterparts.

If meanings about rural health and rural places are being constructed against this conceptual conflation, the disparate and heterogeneous lives of rural people are at risk of being essentialised and homogenised. There were other homogenising ways the academics spoke about rural communities. Firstly, when referring to rural people they tended to use collective terms that construct rural communities as one distinct group. For example,

*“ certainly the debriefing needs to happen . they need to be able to talk about rural people . their experiences in rural communities ” (PAFL: 4076)*

The label ‘rural’ is commonly used throughout the data as a social marker of difference. Within the field of rural health there have been so many attempts at defining<sup>95</sup> rural people and places that the act of labelling is now accepted as normal. Both the rural sociological and rural health education literature draws attention to the problems associated with the quest to find an all-purpose definition of ‘rural’ (Halfacree, 1993). In some theories of language (see Butler, 1993; Derrida, 1976; Saussure, 1974) the act of naming something is automatically an act of giving it an otherness. These theories are useful for considering rural labels in terms of what Derrida calls an ‘absence’ (Derrida, 1976, p 52). He argues the present is only present on the condition that it alludes to the absence from

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<sup>95</sup> There are over 250 informal definitions of “rural” used in research studies (Bosak & Perlman, 1982) and several formal classificatory systems for defining rural populations and places (Rural, Remote and Metropolitan Areas classification systems (RRMA), Accessibility/Remoteness Index of Australia (ARIA), Australian Bureau of Statistics (ABS), the Griffith Service Access Frame (GSAF) and the Rural, Remote and Metropolitan Areas Classification (RRMAC) and the Commonwealth Department of Health and Community Services—Rural and Remote Area Classification (RaRA).

which it distinguishes itself (Derrida, 1976). The act of constituting rural communities as geographical, statistical and social entities is therefore an act of erasing this distinguishing mark and rendering them absent from constructions of mainstream Australian society. It is an act of rural othering.

Secondly, the academics tended to talk about rural communities by emphasising how different they are without any clarification of the meanings associated with this differentiation. For example,

*“... in effect they are different places . [students go to] the community pharmacy . then multipurpose centre . ... because they usually get to do something that has something to do with the different industry that is in the area as well . they go to the school . they go to the doctors surgery . these are all different to what they might be used to” (PAFI: 3965)*

When rural communities are spoken about in such narrow terms of difference there is a tendency to understand them in homogenising ways. Such representations of rurality have been criticised because they tend to describe rural areas and do little to explain the differences between rural places and the processes affecting them (Yarwood, 2005). Some commentators (Hoggart, 1988) argue the differences between rural and urban places are negligible. These have led to calls for constructs of rural to be entirely abolished and for researchers to refocus their time on understanding processes of social change (Hoggart 1988). Others (Halfacree, 1994) argue there are differences between rural and urban areas and the definition should be tailored according to the task at hand (Pitblado et al., 1999). More recently, efforts have tended to concentrate on how rurality has been perceived by different people and organisations (Cloke, 1999;

Cloke, 2003; Cloke & Little, 1997). This suggests that particular constructions of rural work for particular purposes (Dillon & Valentine, 2002).

Thirdly, when the academics spoke about rural communities they tended to emphasise the notion of disadvantage. For example,

*"...I know what it is like for rural people . you know [name]. every year [gender] goes off to the bush and we have no idea what [name] does when [gender] goes off . but when I went ... I just about shat myself . no mobile phone . no car . no alcohol . isolated . no ATM machine . there is no doubt about it . rural people have got it tough and are facing a lot of difficulties . it is very hard living in these places and that's what I try to get across to the students"* (NAFI: 3858)

Within the field of rural health many educationalists and researchers have represented the rural voice to highlight the difficulties faced by people accessing health services. While this may be well-intended, it may also have the effect of grouping all rural communities together as disadvantaged and different. Some sociological researchers (Cloke, 1999; Cloke, 2003; Cloke & Little, 1997; Shucksmith, 1994) call for greater diversity to be acknowledged in rural research, education and policy making areas. They argue that without some acknowledgement of diversity, homogenous language use may perpetuate processes of rural othering. In the rural sociological literature (Daniels, 1992; Yarwood, 2005) there are calls for educationalists and researchers to allow rural people to speak in their own words about the issues they consider important.

Making the voices of rural people more audible within the field of rural health would introduce and ensure a multiplicity of voices, and therefore perspectives, were being represented. Some of the practitioners in this research

spoke about the way the 'rural' label is imposed on rural communities by external groups. They suggest these labels give rise to a set of meanings that are not always accurate representations of rural life, as the following interview excerpt shows:

*"... in years gone by we were never really classed as rural . okay . we were . like district hospitals . we have probably had that name for about 10 years and I think it was probably put on us on a positive note . but I don't think it has been achieved because we are seen to be a bit of a backwater creek ... I really think that it was the university that labelled us when they starting sending students . for their clinical practice . yeah . and there has been absolutely wonderful changes . and we do feel um um part of the whole process . whereas this rural thing . um . . remember that thing she wrote . the nurses gave us the name jack of all traders master of none . which is true but then yeah we have been put in that box and labelled as that . and I don't know that that is such a good idea . yeah I mean it makes us appear a bit different . but perhaps we shouldn't be classed as rural"* (RNFI: 4329-4233)

This excerpt powerfully demonstrates how the use of the classification system to denote different population sectors can have unintended consequences. In this instance, the classification has become imbued with negative stereotypical meanings. Imposing the 'rural' label on certain communities can also be seen as a marker of difference. While the health professional is uncomfortable with its othering connotations the literature shows there are instances where being conceived as the same can create just as much tension. In a recent letter to a journal editor, Ledingham (2006, p 1) wrote, "... watching the evening news of late it would seem there are many who have decided that community is about sameness, and that difference is to be feared. It saddens me to think I am living in a time and place where the wonder of diversity is not recognised or celebrated". Some commentators (Yarwood, 2005) suggest that making rural people's voice more audible may reveal how their understanding of rurality

influences their behaviour in it. It is a suggestion that may be worth considering in the field of rural health and rural health education.

Without the rural voice being sufficiently audible in the field, the academics seemed to rely on their own interpretations of rural difference. One way they attempted to make some sense of rural difference was by using their own metropolitan background as a frame of reference, as illustrated by the following interview excerpt:

*“... like the students who were at [name of town] the other day . it's the notion of fitting it . they don't want to stand out . um . they don't want to be seen as different . but they are different to that rural group” (NAFI: 3812)*

One problem that can arise when particular groups are othered, is social division. Some theorists argue that othering sets up two binary categories, being ‘us’ and ‘them’ (Butler, 1993; Mouffe, 2000). These binary categories emphasise difference over similarity and ignore what people share, in favour of what divides them. Understanding rural and metropolitan people as ‘opposites’ (Rose, 1995) may be one reason why Georgie formulates arguments about students ‘fitting in’ or not ‘fitting in’ with ‘rural groups’. Nevertheless, it is a deterministic view of culture<sup>96</sup> and the need for students to be socialised into it. Contemporary socialisation theorists (Clouder, 2003b) emphasise individuals capacity for agency because shared understandings are negotiated through spoken language and other social practices (Michael, 1997). This suggests that students will reach a shared understanding of what it means to be a person learning in the rural context

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<sup>96</sup> Determinist accounts of culture were discussed on page 1613 and 1773, and argued as a problematic perspective for rural health education.

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rather than automatically seeking to fit in (which is a discussion taken up in the next chapter).

The patterns of language used in rural health education are significant in terms of the meanings that may be being produced about rural communities. Meanings are never entirely in the control of either the speaker or the listener, but always affected by the language system. The following interview excerpt illustrates how the academics language carried unintended meanings about rural communities:

*"... we tell students your mobile telephone will not work . some of your credit cards will not work . but when they get there and they do not work they are devastated and they wish that we had told them . so . sometimes it doesn't matter what we say it doesn't sink in these places that are different and don't have the same services we are used to here . [name] took a group of students to [place] last week and there is only one IGA superstore and like one and nothing else . and when she drove in she said this is it. they [the students] appeared to be slightly traumatised because they just didn't get it that was all there was" (NAFI: 3787)*

In this excerpt, the academic's intention is to prepare students for their rural placement experience. The language used for this task draws upon notions of rural disadvantage and difference. One of the unintended consequences of using loosely defined constructs of difference and disadvantage is rural place is at risk of becoming represented as a backwater with only basic services. Representations are important because they reflect and affect the ways in which rurality is not only understood, but also used, by society (Yarwood, 2002). These findings suggest the pedagogical space is an interactive site through which intended and unintended multiple sentiments about rural people, places and practice are

shared between academics and undergraduate students.

The language used in the pedagogical space for rural health education may be sustaining a hidden curriculum. For instance, emphasising notions of rural difference and disadvantage to students when preparing them for their rural placements imbues this well intended talk with meanings of potential risk and harm. For example,

*“... the purpose of pairing them up is to get them out there easily I suspect . because it is their first placement it is too daunting to send them out by themselves . it's pretty harsh out there . we need to make sure they are safe ... in hospital placements they go in four but it is very much they are individual when they get there . no this is the only one they go out in teams .... because we actually thought it's such a long way away to be if there is just one of you . its revolting . so there you would send up two that knew each other” (PAFI: 4013-4018)*

In this quote, the notions of difference and disadvantage are no longer being used to raise awareness about the difficulties rural people are experiencing in rural communities. They are being used to inform students about the difficulties they will experience during their time in the rural community. The academics talk to prepare students for their rural placement, and strategies to minimise the social dislocation they may experience, is well intended. At the same time, it is a disabling use of language for rural communities because it once again conceptualises them in inaccurate ways. Some commentators (Little & Leyshon, 2003) suggest that contemporary ‘understandings’ of rurality are linked to the notion of the competent and disciplined bodies. The rural body is often set against the metropolitan body. Through resulting contrast is the rural body is seen as ‘defensive, passive and sensually deprived’ (Little & Leyshon, 2003, p



262). Others (Philo, 1992) claim the over-representation of white, middle-class men in rural studies has constructed rural places as 'beastly places' (Philo & Wilbert, 2000). These cultural representations may be influencing the way academics organise the students for their rural placements.

The academics recognised rural communities as harsh and potentially challenging places for students to undertake their clinical practice rotations. As such, the academics considered it appropriate to implement measures to protect students from all forms of distress. The following excerpt shows how one academic tries to combat this risk by organising for students to undertake their rural placements in pairs:

*"... it depends on how much time we have spent preparing the students for an isolated experience . so . I went to the desert over the summer . so now I know what it's like to be isolated . so we make a big deal of it . name and I . start three weeks before the students go out . every week we speak about what does it mean to go to a smaller environment . what does it mean to go somewhere isolated . what does it mean to go somewhere where your mobile telephone does not work and there is one shop . we hope that by the time the students get there they realised they might be isolated"* (NAFI: 3761)

Some researchers have reported that undergraduate students experience some degree of 'anticipatory anxiety' (Gray & Smith, 1999) and find the idea of clinical experience intimidating (Maben et al., 2006). The academics awareness of student's anxiety could be one explanation why students are paired up for the rural placement. At the same time, however, the academic indicates that students are not paired up for other experiential placements. While these actions are well intended, they may also be constructing a more problematic view of rural life. Yarwood (2005) argues that understandings of rurality are clouded by

rural myth that form an anti-idyllic view of the countryside. The prevalence of such rural myths may be creating the imagery that gives rise to the academics' understandings of potential ordeal that students might experience during their rural placements.

It is within negative constructs of rural ordeal that academics and health professionals face the task of generating student's interest in rural practice. For this task they tried to market rural practice to health science students using language that reflects their perceptions of the positive attributes of rurality, as illustrated by the following excerpt:

*" ... [we emphasise] more the positives . which are rural life . um more around the lifestyle that you can actually experience . close community . fresh air . picturesque landscape . like who wants to practice as a health professional and own a vineyard . that's the sort of ... so it is looking at the positives of living in a rural area not so much a metropolitan area" (PAFI: 3989)*

These accounts emphasise the positive attributes of living in a rural area as though these traits would be admired by the students and may be connected to students' desire to perhaps want to work in a rural area. The notion of a rural idyll has been documented in rural sociology literature (Little, 1999; Little, 2001). It is a conventional perspective that views rural life as idyllic and is characterised by language that describes rurality as 'peaceful, wholesome, tight-knit, caring, timeless' (Little 1999). According to some researchers, however, the rural idyll is just another myth that constructs rural people and places in simplistic, unrealistic and idealised ways (Little, 1999; Yarwood, 2005). Little (1999) contends the rural idyll seems to have captured the imagination of rural researchers to

the extent that no discussion of rural society or community appears complete without some reference to its idyllic attributes.

Rural life is often categorised by a powerful set of ideological and symbolic representations, constructing popular images of rural ordeal or rural idyll. The practitioners taking part in this research tended to not draw upon these discourses when describing the environments in which they live, as illustrated by the following interview excerpt:

*“... life is just life here . it has its positive features and it has its negative features . it's not so much . there is no one feature of rural life that makes living here an attractive option . life is far more complicated and multi-levelled than that”* (PHF:

4151)

Studies of rural lifestyles show that women, children, homosexuals, black and other minorities have remained largely excluded by rural policies and other media representations of rural culture (Cloke & Little, 1997). They also illustrate the ways people in rural areas may be othered through cultural practices in everyday life. By representing some rural perspectives and not others, the more visible representations are taken as legitimate and authoritative. Rural sociologists have written about the “the mythological principle” (Gill, 2004). It is a principle in which cultural representations often construct “... [r]ural people as necessarily lesser, more backward, and decidedly uncultured people” who are “...simple, backward and hostile” (Cloke & Little, 1997; Yarwood, 2002).

Alternatively, the mythological principle constructs rurality in an unproblematised way as an ‘ideal picture postcard scene’ with unlimited access to a natural and pure environment (Philo 1992). Some theorists (Cloke

& Little, 1997) argue such constructs ultimately lead to the marginalisation of rural people in the most extreme way. Others (Yarwood, 2005) argue these constructs are not an accurate description of the social reality of rural people but a relationship of power.

The academics attempts to talk with students about the nature of life in a rural community using representations of ordeal and idyll were often contradictory to the lived experiences of the rural health practitioners. Indeed, as indicated in the following excerpt, some of the cultural constructions of rurality were negatively impacting upon health professionals and their families:

*" ... its difficult at times living here ... you know my kids go to the high school here . and when they go to town they say people call them spud diggers . you know. and it makes it tough for track meets and things like that . and you know . here come the spud diggers at footy tournaments and their going . they're going for basketball . they went for debate and you know oh [town name] you know everybody else has school uniform jackets and we just have our rugby jumpers . and you know even in [town name] we have that reputation ... there was one night when we were going to have a parent teacher conference and we asked our sons you know is there anything you want us to talk about and um he sort of said . oh no nothing in particular . and then we heard him crying after in bed . and you know he's thirteen and we went in and he was just sobbing and saying I don't want to grow up stupid" (GPFN: 4215)*

According to ASCSWC (1998, p 4) the extended period of drought that took place in Australia during the 1980s created a sense of 'crisis in the bush'. The media became saturated with scenes of distraught families being forced off their farms by banks and calls for non-rural communities to help country children at Christmas time (ASCSWC, 1998). These publicly broadcasted representations of the plight of rural Australia raised a general awareness of these conditions rural people were living with each day. Social researchers began to report

that rural areas contained Australia's most disadvantaged populations (ASCSWC, 1998). Some researchers (Little 1999) argue that such depictions of rural people are broadcast through media that has a widespread public access. One outcome of such broadcasting is that meanings infiltrate the public and influence the way groups and individuals think about rural people and places.

While cultural representations of rurality may seem benign, they appear to be significantly influencing the personal lives and experiences of those people living in rural communities. As the following interview excerpt shows, when the practitioners spoke to students about rurality they neither rejected nor took up these representations:

*"... I mean sure there's disadvantages too . and . whenever I have the students I like to spend a fair bit of time talking about the things I like about being in the bush. and ...things that you miss about being in the big city . and just to make them think that it's not just all bad ... it's not a sentence to prison farm being sent out to the bush . that there are some really good aspects to it . and I mean we talk the good aspects up . sure we make clear that there are some down sides . but try to share my view that on balance um . the good outweighs the bad ..."* (PHEI: 4095)

According to Short (1991, p xiv) it is naïve to suggest rural representations are completely true or false images therefore individuals should not seek to expose reality or truth but to critically question whose reality is this being represented. Through their authority as experts, the practitioners tended to expose students to a layered representation of what it is like to live and work in the rural context. It is this multiplicity of voices that rural sociological researchers regard as crucial for constructing balanced representations of rural people and rural places (Daniels, 1992; Yarwood, 2005). For the students taking part in this study, these

layered representations of rurality formed the conditions through which they constructed meanings and shaped their identities during the rural placement (discussed at length in chapter 7).

By drawing upon their personal experience of living in the rural context the health professionals predominately represented the rural community as a cohesive network. For instance,

*"...on the whole we are pretty healthy here . you pretty much find the same trends as everywhere else . sometimes you find the values in the rural community go . often in the rural areas you find that ... on the whole they try not to use the hospital for every little thing . they will tend to stay at home and put up with things because we don't have the services that you find in the bigger cities . yeah I think people are a bit more stoic and try and fend for themselves . we tend to band around and support each other . and now that I have said that it isn't always the case but a lot of the time it is . they will stay at home if they've got pain and the will just ring the doctor . but I don't necessarily think that's different to what happens anywhere else . its not a rural trait . its just what happens ... they tend to use friends a lot more ... we are a cohesive community . sure we have some things that challenge us . but on the whole we manage . you have to really". (RNFI: 4255-4258)*

These accounts present a picture of rurality that portrays a healthy, functioning, cohesive and resilient community capable of sustaining the social wellbeing of its members. It is a narrative in which the community is not only surviving, but thriving in ways that are underpinned by values rather than through the intervention of external groups. These representations resonate with the way the Australian government has organised rural development policies. Health status is influenced by factors such as employment, education and housing (Mahnken 2001). The current Australian government assumes there is a level of social cohesion in rural communities. Under the current leadership, improvements in rural health are dependent on 'getting the fundamentals right'

(Australian Catholic Social Welfare Commission, 1998, p 7) in terms of efficient operation of markets and services. These policy prescriptions encourage self reliance and adaptiveness on the part of individuals and communities (Australian Catholic Social Welfare Commission, 1998). It is a position reflected by the primary health care focus in the more recent national rural health policy frameworks (1999, 2003) that aim to contribute to good health rather than a singular focus on the biophysical context of health status.

In this study, the rural health practitioners believe it is important for students to understand the rural community is healthy and thriving, as the following interview excerpt shows:

*"... the service clubs tend to be a pretty important part of the communities in the rural towns . and professional people . are pretty quickly invited to be part of that group to be part of it . and get involved in community group stuff . here . [we] are very heavily involved . all of them are involved in the church groups . but nearly in every rural town . if you go around the country you will find that the pharmacist in that town is on bloody everything . half the time they are on the council . they are the mayor . they are the . they are in the service club . they are in the Rotary club or the Lions club . they are on the school parents and friends . they're on the sports committee . on the nursing home board . the pharmacist tends to be very . if you look around the pharmacists in the towns are often the key people in the community . always that stuff that you do for nothing . so and . so we expose them to that"* (PHEI: 4097)

Some theorists would consider these new accounts of rurality to be an integral feature for disrupting the myths surrounding excluded groups. For instance, hooks<sup>97</sup> (1994) argues that an interactive teaching approach is one way of validating the marginalised voice. Her writings suggest that by including rural

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<sup>97</sup> bell hooks is a black feminist who does not capitalise her name in any publications, therefore she is cited appropriately.

health professionals voice in students learning experiences fosters a learning relationship in which 'everyone's presence is acknowledged' (hooks, 1994, p 8). In theory, the rural placement can be understood as an 'engaged pedagogy' (hooks, 1994). This suggests the relationship between students and rural health professionals have the potential to challenge and disrupt the marginalising constructions of rural people, places and practice that circulate in Australian society. It is a teaching approach that some educational theorists consider to be central to the project of recovering forms of knowledge that characterise otherness (Aronowitz & Giroux, 1991).

Some of the social activities that students were involved in placed them at the forefront of local community members uniting to address some of the social issues that directly impact upon the community's health, as the following field note shows:

*"Rotarian: ... somebody should be pushing to show how much the community puts in . for example the nursing home . volunteers put in and got that started . we need a lobby group to get started . NOW . a lot is expected . why should rural areas Mim: there is no equity between rural and urban areas despite what the politicians are telling us . rural is expected to run the ambulance and the fire brigade here . I . um haven't go an answer . would we have these if it wasn't this way . day care wouldn't function without volunteers here . but a lot is expected of volunteers in rural areas . Rotarian: ... yes we do need to push the message that we are at a disadvantage . also we need to consider if it was not for volunteers we may not have got the 3.8 million this time" (PHFN: 471-473)*

This excerpt illustrates how the orchestrated social activities exposes students to the way the community activity engages in a group discussion about how they might respond to the social problems that may be affecting the community's



health. In planning how they might proceed with political lobbying community members tend to use language of rural difference and rural disadvantage. This is apparent through techniques of labelling, the 'us' and 'them' distinction, and comparison of differences between rural and urban groups. In this instance, the power of these techniques of categorisation emerges from planning dialogue between those trying to activate rights or make claims on those with the power and authority to reallocate resources and services (Wood, 2007). In this dialogue, labelling is nothing more than a rationing and allocation activity and therefore a mode of distribution and redistribution. It is not intended to be an accurate description of social reality; it is simply a relationship of power.

While the practitioners were aware of the political means of using notions of rural difference and disadvantages to achieve a political ends, they rarely explained this rationale to the students, as the following field note demonstrates:

*"... don't be put off . working in a rural area is really great . but . well as you can see how hard it is for us to manage with limited resources here . we have to work really hard to get any support from the government . it's a constant struggle to do what we have to do with the limited resources we have . rural areas are so very disadvantaged in that regard"* (PSFN: 218)

The language of difference and disadvantage may be sustaining discourses of rural ordeal. The students are now hearing this discourse at different levels, in different contexts and from experts who are recognised as highly authoritative. As such the discourse of rural ordeal attains a high degree of legitimacy. Moreover, while the language of difference and disadvantage is a political means and strategy these relations of power are rarely made explicit to the students.

Consequently, they are hidden and invisible. The difficulty for rural health education is, what does appear to be visible to the students are representations of rurality that emphasise the rural ordeal of living and working in a rural community.

The orchestrated social activities, and everyday social requirements of living, introduce students to a variety of people in the rural community who did not always share the goal of attracting the students to the rural community to live and work, as the following field note shows:

*“Technician: that’s [place] over there . there’s a lot of weird people up there . they have unusual ways  
Sarah: in what way?  
Technician: oh they have lots of nice shops and things . you know .. odd tourist things [students continue to stare at the bushland silently] . they have a replica of a tin mine that kids love .  
Sarah: but how are the people odd?  
Technician: just are . lots of outlying areas . they are different . they are like hippies . like weird . but really nice people . there is one lady that comes into the pharmacy . she wears a witch cross around her neck . she is on a cocktail of things . so many drugs . and she still manages to drink lots” (PTFN: 755-759)*

Thus, the design of the official academic curriculum ensured knowledge was taught in a value laden way that privileges particular groups. It also appears the rural placement became a text that reinforced the marginalising constructs of rural difference and disadvantage. As such, a tension was created between the official curriculum of raising student’s awareness of the positive attributes of rural practice (ie. what health professionals say about rural life and rural practice) and the informal curriculum of what rural people say and do as they live and work in the rural context. It is well documented that the hidden

curriculum is as much the experience of students observing the social actions of people in the social world, as being taught an official curriculum (Hafferty & Franks, 1994). Indeed, hidden curriculum theorists argue that students are more likely to adopt the attitudes they observe people demonstrating in the hidden curriculum than the values they hear teachers talk about in the official curriculum (Feudtner, 1994). It was through these unintended meanings that the hidden curriculum reproduces cultural attitudes that exist in society and reinforce the relations of rural difference and disadvantage.

Rural community members recognised the students as outsiders to their community and therefore treated them as such. This was particularly well reflected in the following field note:

*Bob: as well hello girls . where are you from?*  
*Bronwyn: we are both from [metropolitan city]*  
*Bob: ah . city girls hey . some of them . . so what have you done socially in the town . what have you done to get to know us (PSFN: 418-422)*

Throughout the entirety of the rural placement the notion of difference was reproduced in the talk with students. It was an account of difference that highlighted to students they were in a different place and engaging with a community to which they did not belong. Throughout the data there are many instances in which health professionals, and others, illustrate their narratives about rural life by drawing comparisons to the metropolitan experience. Some social identity theorists argue that groups establish their boundaries by defining who they are by ascertaining who they are not (Tajfel & Turner, 1986). It is a process that reinforces the idea that rural and urban groups are

opposite (Rose 1995) and perpetuates rural othering. Moreover, it is a discursive process that strengthened the two binary categories, of 'us' and 'them' (Butler, 1993) that had been established in the higher education context<sup>98</sup>. While it was a powerful marker of division, this use of language was not designed to construct notions of social division. It was designed to construct a positive image of rurality in order to generate students in living and working in the rural community as future health professionals.

In the last excerpt, the students were presented with the question, "*...what have you done to get to know us*" (PSFN:422). It is a question that highlights the notion that students are active agents in their socialising experiences of rural health education. It shows that while academics and practitioners can influence the way students think and act in rural health education, the students are expected to play an active role in their teaching and learning experiences. These concerns are taken up further in the next chapter.

## SUMMARY OF FINDINGS IN THIS CHAPTER

A number of arguments were developed in this chapter. These include:

- the university uses a core curriculum for students to develop knowledge, skills and attitudes in their preparation as generalist health professionals by focussing on patient-centred, holistic approaches to care and health service delivery;

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<sup>98</sup> Refer to chapter 5, for the discussion of the 'us' and 'them' distinction in the institutional space of health science education and to chapter 6 for a discussion of how the students responded to these classificatory systems.

- the health science academics recognise generalist health education as a way to address the acute health workforce shortages that are impacting upon all areas of Australia;
- rural health education has been included in the generalist core curricula for undergraduate nursing, medical and pharmacy students in order to address the rural health workforce shortages;
- the presence of rural health education, as a distinct topic area in a generalist core curriculum, created tension for the academics;
- in terms of rural health content the academics seem to be working from an uninformed position and therefore respond by:
  - refusing to focus on 'rural' content and insisting the teaching and learning focus remain generic;
  - adapting existing generalist curriculum content to give it a 'rural' focus;
  - delegating rural health teaching responsibilities to external guest lecturers and rural health practitioners.
- the academics recognise the rural placement as another context for students to learn knowledge, skills and attitudes in actual health care agencies in order to professionally develop as emerging health professionals;

- the academics appear to be indifferent to generating students interest in rural practice and consider this outcome to be a surreptitious corollary of rural exposure;
- during the rural placement the rural health practitioners understood their main purpose of facilitating students learning as preparing them for their future roles as generalist health professionals;
- the busy demands of rural practice meant the rural health practitioners were often struggling to meet the dual needs of clients and students and therefore often resorted to task oriented and technical approaches to care and health service delivery;
- the rural health practitioners also recognise the rural placement as an opportunity to attract students to rural practice and so organise several activities to immerse them into aspects of rural life, and
- both academics and rural health practitioners use language to talk about rural people at an individual and social level in ways that give rise to several unintended (hidden curriculum) meanings, including:
  - rural as the medicalised other;
  - rural people, places and practice are different and disadvantaged (rural deficit), and
  - rural places are both idyllic and an ordeal.

## CHAPTER 6 STUDENT AGENCY IN THE SOCIALIZATION PROCESS

### INTRODUCTION

As undergraduate nursing, medical and pharmacy students moved through their rural placements they became involved in a process of professional socialisation and identity formation. How does rural health education shape undergraduate nursing, pharmacy and medical students' personal and professional identity?, was a key question in this research. In this chapter the analysis of field notes and interviews created from the period of observation-of-participation and the language texts created from the semi-structured interviews with the students is presented.

The analysis shows the process of professional socialisation the students underwent during the rural placement. This was an intensive period as students moved through various phases as they became more deeply committed to their professional roles and identities. There were several components of professional socialisation that the students moved through during the rural placements. These include anticipatory, formal, and informal, which are used as the conceptual grid for organising the sections in this chapter. These findings are similar to the levels of role acquisition described by Thornton & Nardi (1975). Thornton & Nardi (1975) argue these as phases of role acquisition where individuals pass through a

serial passage of sequential levels. Each level reflects a more intense commitment to the professional role.

In this study, students' identification with, and commitment to, the professional role did not progress as a linear achievement. Rather than mastering each phase before moving into the next, the students oscillated between the various phases of professional socialisation. Student behaviours and identities changed according to the interaction and expectations of health professionals working with the students in different situations. Each component of professional socialisation required the students to draw on different dimensions of their personal and professional identities. In other words, the students moved backward and forward between their student, emerging health professional and personal identities. It appears there are different dimensions and commitment to identity that overlap, rather than being mutually exclusive.

## UNDERSTANDING THE RURAL PLACEMENT

This section analyses the way undergraduate nursing, medical and pharmacy students understand the rural placement. It shows they predominately understand the rural placement as a context from which they can professionally develop as health professionals. Arrival to the rural placement was a daunting period that involved a high degree of anxiety. These feelings were intensified when the students first commenced the clinical component of the rural placement. They were aware that their prior knowledge of professional practice, the student role to which they had become accustomed, and their



knowledge about rural communities were all about to change. The students expected to undergo a process of transition whereby they would learn and acquire new norms, and ways of being in the clinical and professional setting. This period of socialisation is known as anticipatory socialisation (Thornton & Nardi, 1975).

The students commenced the rural placement with the expectation they would extend the attitudes and values necessary for their development as health professionals. They understood the rural placement would involve them in new situations and allow them to familiarise with the intricacies of performing the health professional's role. As the following field note excerpt shows, the students therefore viewed the rural placement as a pivotal event in their professional development as doctors, nurses and pharmacists:

*'... I am really looking forward to this . there is so much I want to learn . I mean we get to dispense scripts at uni and stuff like that . but actually being here in a pharmacy and dealing with customers and seeing how it all comes together is going to be fantastic . this is what I have been waiting for since we started our course'*

(PSFN: 267)

The students had almost total consensus on what they considered to be important during the rural placement, and what they expected from it. They expected to learn about professional practice from health professionals and work with patients. These expectations reflect the educational preparation, learning, and predisposing experiences that precede the student's entry into the rural context. As Merton (1957, p 265-271) indicates, the process of professional socialisation commences even before students enter their undergraduate

programs. It is then shaped by various socialising agents, such as academics, public media and curriculum content, as soon as the course commences. As such, the students entered the rural placement with a host of prior experiences and learning. It is a phenomenon that has been referred to as 'anticipatory socialisation' (Merton 1957; Thornton & Nardi 1975; Porter, Lawler & Hackman, 1975; Schein, 1968; Van Maanen, 1976). These prior attitudes, beliefs and abilities influenced the students experience and adjustment to the rural health care setting.

In anticipation of the rural placement, the students developed expectations and tried to prepare for their experiences in the health care agencies. As the following field note shows, commencing the rural placement and thinking about what might occur in the health care agencies was a stressful stage as the students developed expectations of themselves:

*"Ann: I am a bit nervous about this . [Lily laughs] . I have been worried all week . I just don't know what to expect . what if we can't remember everything . what if they expect us to just get and go .*

*Lil: [laughs again] yeah I know I have been too . but we are here to learn so I guess we will get the gist of it as we go . probably learn some new things too "*

*(NSFN: 853-854)*

Modern society provides students with multiple sources of background information about life and their pending work roles and identities. Research shows the attributes that shape students view of the professional world includes, personal background, prior employment history, family and friends, public media, and the nature of the primary, secondary and undergraduate educational programs (Tolhurst & Stewart, 2003; Tolhurst & Stewart, 2004). These

prior learnings are one of the main social conditions that impact on the process of professional socialisation (Bucher et al., 1969). As students develop expectations of themselves, each of these influences can contribute to feelings of anxiety as they enter new situations. Some researchers have attributed this 'anticipatory anxiety' (Gray & Smith 1999, p 641) to fear of the unknown in the professional setting (Bradley 1989, Keck 1990, Jowett et al 1992, Davies et al 1994). Others (Katz, 1978; Van Maanen & Schein, 1979) suggest individuals are in a tension-producing transition as they attempt to establish an identity within new professional settings. The degree to which an individual's prior expectations match the new situation may ease the adjustment period (Katzell, 1968; Dunnette, Arvey & Banas, 1973; Wanous, 1977; Mobley, Hand, Baker & Meglino, 1979).

Entry into the health care agencies created several stressors for the students. Engaging with health professionals, dealing with their performance expectations, interacting with patients and possibly causing them harm, and fears of an inadequate knowledge base, all caused the students a high degree of anxiety. As the following excerpt shows, this stress was further compounded by the pressure to complete academic assessment tasks during the rural placement.

*"... I am feeling a bit stressed about getting everything done while I am here . the workbook has to be finished before we leave . my assignment is only half done and no doubt we will be to do more and more work on the wards . there is so much to take in . but I am not going to get all worked up about it though ."* (NSFN: 1768)

Much of the learning undertaken during the rural placement formed the basis of the assessment requirements for the students to pass their academic

units. The assessment items required students to provide various documented evidence of their competency development. Although working towards competence is dependent on professional development, the students saw these two areas as distinct. Tensions between the expectations for learning in the higher education setting and students experiences in the professional context have been well documented (Shead 1991, Yung 1996, Corwin & Taves 1962). Certainly, the dual demands and expectations from the academic and professional areas created role and identity discrepancies for the students participating in this study. The academic setting required the students to primarily enact their learner identities, whereas the professional setting required the students to enact emerging health professional identities.

In order to undertake a rural placement, students have already been through sets of prerequisite coursework. Meeting these academic prerequisites presupposes they have met the basic knowledge and skills upon which their clinical practice experiences will build. The character of this prior socialisation had implications for how the students coped with entering the rural health care agencies. The following field interview excerpt shows how the students relied heavily on their learner identities when they began to engage with the professional environment:

*“ ...we fit in as a student . who is different to a carer and the nurse ... as students we kind of had a really cool role in that they recognised that we were learning and knew stuff . and they asked us quite a bit and were interested in finding out about physiological things and it was pretty clear that they respected the fact that we had a growing knowledge base .... but if we got a bit out of our depth we could back off and the nurses would take over”* (NSF: 3523)

Whereas the student identity was primarily associated with processes of learning in the academic setting, the students also tended to rely upon it in the professional setting as a coping strategy. For instance, one student stated “... *I am just learning and as a student I can't be expected to know everything about working in a pharmacy*” (PIFI:269). It is well documented that relationships with health professionals in the practice setting promotes the socialisation of students. As novices, the students had a tendency to observe the health professionals in action. As other studies have shown (Dobbs, 1988; Goldenberg & Iwasiw, 1993; Hovey et al., 1990; Pitkala & Mantyranta, 2003) these opportunities assist students with adapting to the realities of the professional context. From these observations the students developed various ways of making themselves feel more at ease, such as practising skills or researching disease processes and medications. These have been described as ‘coping’ (Gray & Smith 1999) or ‘survival’ (Becker et al., 1961) strategies. As the students were acquiring this knowledge and skill base, they were also being socialised into learning about the values, attitudes, and expectations concerning the role of the rural health professionals.

The preceding socialisation that students have experienced can be more or less commensurate with the actual social conditions of the rural placement. Whereas, the academic context tended to focus on the clinical and practice dimensions (as discussed in chapter 5), the health professionals were adamant that students should learn about the community as a social entity (as discussed in

chapter 5). The following field interview excerpt shows the expectations relating to these social dimensions of learning were not a cause of anxiety for the students, but instead a source of interest:

*"I haven't spent much time in a rural place so I don't know what it is like . its quite different to where I have grown up and lived my life . so the idea of staying here was really exciting to me . I can go hiking and biking and see a bit of the countryside . it's a bit of holiday for me I suppose"* (NSIFI: 278)

Students saw the opportunity to stay in the rural community during their rural placement as an opportunity to explore and experience another place. They considered there to be a big difference between the city life and rural life. The students were particularly interested in learning "... *what rural people are like*" (MSISI: 2781) or "...*what it's like to live in this rural place*" (PSISI: 492). Helen Tolhurst (2006) reports a similar finding in which medical students undertaking a rural placement had very little experience of rural life, but were open to learning more about it. For the students participating in this study, the desire to learn about rural people and rural place was understood to be more than a passing interest. It was interpreted as an indication of the students' sense of self or social identity. Identity theories suggest that an identity locates individuals relative to others in a situation (Tajfel, 1978; Tajfel & Turner, 1986). Thus, questions of 'who we are' are often intimately related to questions of 'where we are not' (Tajfel, 1978; Tajfel & Turner, 1986). The desire to learn more about 'rural people' or 'rural place' can therefore be understood as the students wanting to immerse themselves in aspects of rural social life in order to identify with others and themselves. Perhaps students saw and took up the opportunity to learn about rural life

because they understood it as a different place they could explore.

The students understood the rural community as a homogenous entity with a common social class that shared similar beliefs and values. The idea of learning about those beliefs and values was an exciting and new prospect; therefore, they approached their stay in the rural community with a sense of adventure<sup>99</sup>, as the following field note shows:

*"I can't wait to get out and go exploring . I am such a city girl so the idea of getting out and about on a farm . or messing about in the bush is quite intriguing for me . I am not sure how I will go . but I guess we will meet some rural people and find out what life is like for them". (NSISL: 1674)*

A number of socialisation and identity theories recognise that all community settings and geographic places convey cultural meanings (Becker et al., 1961; Clouder, 2003b; Weidman, 1989b; Weidman et al., 2001). These shared ideas and beliefs shape social behaviour and individual's sense of self. Anthony Giddens (1984) argues the critical feature of places, or 'locales' is the way in which particular *"... features of settings are [...] used, in a routine manner, to constitute the meaningful content of interaction"*. Ways of appropriately defining and classifying rurality are a main point of conjecture within the rural health education literature.<sup>100</sup> Similar discussions about the nature of rural place are rarely a focus of empirical or theoretical inquiry. It is a neglect that has impoverished our understandings of students experience of rural placements because as Pile &

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<sup>99</sup> These findings are encouraging for rural health education to possibly achieve the goal of attracting students to rural practice. This is a discussion taken up further in chapter 7.

<sup>100</sup> Please refer to chapter 2 for the discussion on rural definitions and classification systems.

Thrift (1995, p. 380) observe ‘... *subjectivity and place cannot be separated without foreclosing an understanding of the located subject and the agency and identity of place.*’

As the remainder of this chapter will show, these are important considerations for the field. It was through students’ immersion in place and the formation of relationships with people in the rural context they were able to create and sustain a coherent sense of self and to reveal themselves to others.

The differences between the student’s anticipations of undertaking the rural placement and its reality, created the opportunity for new learning and the need for adaptation. The following field note shows how the students were open to all possibilities of learning about the clinical and non-clinical dimensions during the rural placement:

*“...[pharmacist] took us through the computer and how he dispenses medications . how the systems all work . we just got a good look at how it all works in rural areas . we had a good talk about how the bus goes out and back in again delivering medications to people . its pretty good though you know same day service and all . mostly we spent the morning just hanging out there . watching people . following them round . look and listen . nothing too exciting or strenuous . we are having a really good time here though . there is so much for us to learn . more than just practicing medicine . its about how they work together here . what the people are like here” (MSFN: 2093)*

The anticipatory socialisation period is an important phase of socialisation. It has been described as an arena with an open boundary (Shuval 1980) for individuals to prepare for their future roles, positions and social relationships (Appelbaum & Chamliss 1997). For the students in this study, it was the period in which the students developed images of what might be expected of them as health professionals. It was also the period in which they began to prepare themselves



for how they might not only fit into their professional cultures, but also how to fit into the rural culture. The students were committed to their development as health professionals and open to learning about rural culture, the rural placement therefore had the potential to have a lasting impact on students. As the remainder of this chapter will show, the cultural messages that emerged from both the academic and rural placement settings had both a positive and negative impact on the student's professional development and identity formation.

#### FORMAL PURPOSE OF THE RURAL PLACEMENT

Rural placements are constructed by academics and rural health practitioners as a component of the generalist core curriculum and also as a rural health workforce supply strategy.<sup>101</sup> In this section, the analysis focuses on what the undergraduate nursing, medical and pharmacy students understand as the formal purpose of undertaking the rural placement. It shows the students consider the prescribed purpose of the rural placement to be engaging with health professionals, and patients, in order to professionally develop their clinical and professional knowledge and skills. Entering the health care agencies and engaging with the rural community symbolised a new phase of socialisation for the students. There were three components of this formal stage of socialisation; learning the culture, surviving the culture, and internalising the culture. These are used to conceptually organise this section. They show how students'

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<sup>101</sup> These constructions were presented and discussed in chapter 5.

expectations about meeting rural people, and learning about professional practice were met with the reality of being in the health care agencies.

### *LEARNING THE CULTURE*

The rural placement process shaped the professional socialisation experience of the undergraduate students. The formal component of this process consisted of knowledge necessary for students to practice as a health professional. For the students, it was knowledge that challenged their high level of altruistic intent, as shown by the following field interview excerpt:

*"I am just totally blown away by how busy we are on the wards . I imagined myself talking with the patients and making them feel better . I am so preoccupied with keeping up with the nurses that I hardly have enough time to say hello to a patient"* (NSIF: 1059)

Helen Tolhurst reported similar findings in her study of medical students experiences of rural placement. Unlike the students in Tolhurst's (2006) study, the idealistic notions held by the students in this study were not driven by a desire to make a difference to the lives of rural people per se. Instead, they appeared to have a more general sense of calling, "...to make a difference to society " (MSISI: 1983), rather than any sense of concern for any particular social group. During this stage of professional socialisation the students' altruistic expectations met the reality of the busy organisation demands. Other studies of organisational socialisation (Hughes, 1958; Porter et al., 1975; Feldman, 1981) discuss the damaging effects of 'reality shock' that may ensue (Gray & Smith 1999; Hughes, 1958; VanMaanen, 1977). The students in this study were shocked to learn how demanding rural practice can be. There also quickly

realised the health professionals expected them to keep up and participate in aspects of clinical and professional practice. It was a realisation that increased their feelings of anxiety because they recognised themselves as people who had not yet acquired the knowledge nor sufficiently mastered how to behave like a health professional in the professional setting.

The formal professional socialisation process is the stage where students are inducted into the professional programme. The students quickly realised the way they behaved as learners in the academic context differed from the way they could act as learners in the professional context. The following field note shows how the rural health practitioners made students aware of appropriate and inappropriate learning behaviours:

*“Pharmacist: Okay ... this is FRED [pointing at the dispensary computer] . that stands for Fast Reliable Entry Dispensary. [the students position themselves either side of the pharmacist and concentrate on the computer screen. Bronwyn opens a small note book and gets her pen ready]*

*Pharmacist: you won't need that . pop down and just listen before you can have a go . I like it . its good” (PSFN: 59-60)*

At first, even the simplest tasks, such as speaking with a patient, were often too confronting for the students. They implemented various learning strategies to acquire the knowledge of what professional practice involves and how to go about it. Initially, the students achieved this by taking notes and reading from their text books. The considerable tension surrounding reading and writing practices other than clinical documentation in the professional setting is discussed by Street (1992a). Health professionals consider the provision of health care to patients as their priority. Extended periods of reading and

writing are considered as an inappropriate use of time (Street 1992a). In professional practice, time is a precious commodity that should not be wasted on such meaningless activities (Street 1992a). The students quickly became aware of the health professionals expectation they should become involved in professional practice activities. It was an expectation that led to the students realising their identity had to change. The students realised that learning had to be achieved through a less obvious mechanism.

During the rural placement, the core professional socialisation process worked as a normative context. Through their observations of the rural health practitioners in action, the students were quick to realise there were particular rules associated with working in the health care agencies that are consistent with being a health professional. For example,

*"... it's pretty regular really . rounds at 8.30 . see patients til lunch time . lunch . then patients again . for each patient you start with a chat . then a listen and look see . then some more chat . then you formulate a diagnosis and plan . give them what they need and off they trot"* (MSIFL: 2145)

From their observations of the rural health practitioners, the students were able to extract the common rules relating to the performance of routines and rituals. The rules that were most apparent to the students were those associated with the daily routines and rituals that take place in the health care agencies. Some researchers term this 'learning the ropes' (Schein, 1984). It is an account that highlights the way the students often learned the clinical supervisor's preferences for doing things in a certain way and rarely questioned their knowledge or practice. Learning the routines in the health care agencies involved

more than simply learning what needed to be done and when. It is also involved learning the culture of the workplace. At this time the students began to familiarise with the health care agencies and made attempt to participate in some aspects of professional practice. According to Feldman (1976) and Schein (1971) formal socialisation processes commence when individuals begin to participate in basic activities in the workplace (Feldman, 1976; Schein, 1971). In this research, learning about professional practice involved three aspects.

First, the students engaged in activities that would involve them in learning the formal knowledge and skills of their profession. The field note shows how the students set about learning about what professional practice involves by practicing basic skill acquisition and performing basic tasks:

*“Nurse: Who wants to do a blood sugar?  
Lil: pick me pick me I have to practice some of my skills and that’s one of them . I have already given a subcut injection . but I just want to make sure I am using the BSL machine properly” (NSFN: 1751-1752)*

Even though many of the students had prior knowledge and experience with clinical skills they saw these as opportunities to achieve some sense of skill mastery. They were interested in details of clinical procedures, the operation of particular equipment and what skills and tasks are required for particular routines and rituals. Manual skills are integral to health professionals’ roles and students need to practice them repeatedly in order to gain competence (Hodge & Oates 2007). Like others have found (Diekleman 1993), the students quickly realised that skill performance was positively sanctioned by the health

professionals and began to increasingly participate in the routines and rituals of professional practice.

Second, the students were interested in learning about the tacit knowledge, norms and values of the profession. The following field note shows how the students made active attempts to clarify the nature of their role and responsibilities in the health care agency:

*Bronwyn : we have finished dispensing those scripts . shall we go back to the drug register now? Is that what we should be doing?*

*Pharmacist: yes ... that's a good idea ... use your time wisely while you are here . checking the register is a really important legislative requirement . just keep going there for a moment . I am busy at the moment but I will get back to you (PSFN: 132-133)*

The rural health practitioners in this study were explicit in their expectation that students should be taking on greater degrees of the workload in the professional setting. The workforce shortages and limited availability of services in rural areas means that in rural practice every day is a busy day. The practitioners often found it difficult to meet the learning needs of students while juggling the demands of their own heavy workloads. Studies have dispelled some powerful myths about supervising students in the professional setting. Health professionals do not necessarily have a longer day and having students does not necessarily decrease productivity (McKee, Steiner-Grossman, Burton, & Mulvihill, 1998). In fact, students may actually increase productivity (Fontana, Devine, & Kelber, 2000; Hildebrandt, 2001). Undeniably, however, working with a student makes a clinical day more complex. These circumstances had a

powerful influence in the way the students came to understand their role and responsibilities in the health care agencies.

Third, the students recognised that the rural health practitioners were a key source of information for learning about the social values, norms and symbols that make up the unique professional culture to which they were seeking membership. The following field interview excerpt shows how the students worked hard to establish new relationships with the health professionals:

*"... we only went to (doctors) and (doctor) was talking about his place and how you can just sit on . like you can spend some nights sitting in the back yard . drinking red wine and watching the stars . and things like that . that was fantastic . just spending social time with the doctors made me feel part of it all . I felt like I was becoming a doctor"* (MSFI: 3658)

For the students these relationships were an important way of feeling part of the professional group. Students who were less successful in establishing such relationships spoke of feeling *"... just so alone here"* (NSFN: 1399), and *"... I hate it here . hate it . just feel so alone . so isolated here . don't want to be here any longer than I have to"* (NSIS: 1409). Students who had bonded with staff members and had begun to participate in social gatherings at morning and afternoon tea did not have these feelings of social isolation. Socialisation theorists argue that as strangers to organisations, newcomers establish new relationships not only in performing aspects of their professional roles, but also in the organisation's informal social network (Nelson, 1987). For the students who did not feel they belong, the rural placement was a long and challenging experience. They quickly

developed strategies for surviving the culture. Several of these strategies were used by students who were more comfortable to maintain the supportive relationships they have developed with the health professionals.

### *SURVIVING THE CULTURE*

During the formal professional socialisation process the students began to shape their professional identity to their specific professional role. As the following excerpt shows this was a crucial period in which the students were careful to protect the relationships they had established with the students:

*"... I don't want to dob . I don't want to piss them off or anything . we just don't want to be dobbers . it's just not worth it . we could just wait it out . its not that much longer . they could make our lives hell if we go on the wrong side of them"*

(NSFN: 1085)

During the formal process of role acquisition students expectations about the professional role can remain idealised (Thornton & Nardi, 1975). Some studies report that students feel powerless and confused by the dichotomy between the ideals of the university and the realities of the practice setting (Willis 1996, Young et al 1988). The students in this study rarely disclosed these feelings to the health practitioners. It was a strategic and planned approach to preserving the relationships they had worked so hard to establish. The students believed if they did not rock the boat or cause trouble their learning experience would be more positive. Another way of surviving the rural placement was to act the part of a health professional. Without the support of the health practitioners the students knew they would be unable to make the transition from outsiders to professional



culture to insiders.

As time passed during the rural placement, the students began to undergo subtle shifts in their professional behaviour and attitudes. They began to shift from viewing the culture of professional practice as outsiders to viewing it as insiders. The following field note shows how the students' began to increasingly participate in task related aspects of professional and clinical practice:

*"... I am so busy though. we are going to have to get going if we are going to get it all done . I still have all those beds to do and it will be time for the drug round soon . gee . its nearly lunch time . I better get moving . they will be waiting for me"*

(NSFN: 1375)

Learning how to behave in the health care setting was more than simply conforming to the prevailing norms – it was also a way of surviving the rural placement. They wanted to create a smooth journey for themselves and they had realised these behaviours were often positively sanctioned by the health practitioners. They began to realise that not wasting time, being busy, acting professionally, and doing the work were all attributes and behaviours that are highly valued in professional practice. Other researchers (Clark et al 1997) have reported that students are reluctant to rely on the supernumerary status in case they are regarded as lazy by the health professionals. Instead, they prefer to be seen as part of the workforce (Clark et al 1997). The nature of the rural practice environment was a powerful determinant on students' professional socialisation of values. As they were inducted into professional culture they determined their own degree of fitness as a professional member. To do this, the

students' relied on the formal knowledge upon which they would be judged.

As well as the immediacy of the rural placement situation the students were also involved in the wider process of professional socialisation. The academics, as primary agents of professional socialisation, held a great deal of power in deciding whether the students were working towards becoming competent health professionals. The following field note shows how the students conformed to the academics expectation they would document evidence of their professional development:

*"... yeah a kid who stopped breathing . the doctor wrote up really good notes . so I pretty much copied 80% of her plan . I reckon I'll get an HD for it"* (MSFN: 2460)

Meeting the dual needs of academia and the heavy workload demands of the health care agencies meant the students were often unable to approach professional practice in a holistic way. One way of surviving the enormous pressure to complete academic and professional work was to bridge the two through learning. The students therefore approached the rural placement as a text from which they could generate evidence of their learning. Patients and health professionals were approached as objects to learn from. At this stage of development, the students' tended not to practice in a way that was holistic or empathic. They quite often neglected the humanistic dimension of health service delivery that is a cornerstone of a health professionals practice. These behavioural approaches to approaching care and organising learning were effective survival strategies for the students. At the same time, they were inconsistent with the philosophy of the generalist core curricula at the

participating university that values holistic and patient centred approaches.

### *INTERNALISING THE CULTURE*

The rural health practitioners were powerful socialising agents who had the power to influence the student's thoughts and actions during the rural placement. The students began to respond to the rewards and punishments from practitioners as they tried to fit in with their professional groups. The following field note shows how the students began to think about other behaviours they might exhibit to demonstrate to the health professionals how they were fitting in:

*Will: so will we get dressed up in our costumes then Todd?*

*Todd: yeah I guess so*

*Will: well I think we should .*

*Todd: what are you going to wear?*

*Will: we will get dressed up like doctors and look the part* (MSFN: 1859- 1863)

Looking the part of health professional was an important aspect of fitting in for the students. Dressing in clothes that resembled health professionals and carrying health professionals' tools, such as the stethoscope, was a deliberate attempt to defy the accepted norms of fashion. Uniforms designate a group—they indicate membership to the group. It has been reported to assume the properties of a totemic emblem. For the students, the uniform offered a stable symbolic social and cultural stability. Wearing the uniform was designed to indicate to the practitioners the student's strong desire to fit in. As the students became more familiar with the health professional role and accepted ways of behaving, they began to move beyond merely enacting the role of the health professional. They began to internalise some of the values, which were

considered important in professional practice, as their own.

The students also began to conform to the norms and values of the professional culture. The following field interview excerpt powerfully shows how they began to embody particular behavioural attributes of being a health professional:

*Researcher: Can you tell me why you are doing that to the medication stock?*

*Sarah: so they are all in the right order and neat. it's been busy and some of them have been knocked out of position .*

*Researcher: You think they have to be perfectly ordered and neat?*

*Bronwyn: they HAVE to be*

*Sarah: [nods furiously] . it's really really important . so we can just grab them as soon as we want them . it's really busy in the pharmacy . you just don't have time to mess about looking for things that should be there . we should be able to reach out and know it's there . that's why it's important for a pharmacist to have their stock in perfect order (NSIF: 584-588)*

As time progressed during the rural placement the students learning had extended beyond simply 'learning the ropes' (Schein, 1984) of professional practice. The students were no longer just acting like health professionals as an effective survival strategy. They were beginning to behave like students in other studies by 'pulling their weight' (Melia, 1987), and "mucking in" (Gray & Smith, 1999). In other words, they were beginning to internalise aspects of professional practice culture. It was no longer an exercise undertaken for learning or assessment purposes: it had become exciting to the students. Researchers recognise this transition in professional development as the internalisation of a particular sense of self (Woodward, 1997), or the emergence of a professional identity. This represented a new stage in the students' professional

development and identity formation.

As the students underwent a process of professional socialisation their commitment to the profession began to become an investment in their development. The following excerpt shows how the students' commitment to their emerging health professional identity rested on objective investments in various aspects of the professional role:

*"... these scripts are building up again . I will get on and dispense some of these scripts . then I can have a look and see what stock might need ordering"* (PSFN: 175)

Exhibiting these professional behaviours is illustrative of the way the students began to accept and legitimise the cultural rules in the health care setting. By learning from and observing health professionals the students were beginning to internalise the values, attributes and beliefs of what it means to be a health professional. This was the point at which they no longer uncritically mimicked their clinical supervisors. They began to make alterations to their actions and approach tasks in ways they considered as appropriate. By acting like independent health professionals the students had become immersed in the process of professional socialisation. They began to accept specific systems of cultural meaning as legitimate. Professional practice had become a cultural meaning system and from these cultural texts the students began to undergo an interactive process as they internalised the culture.

Along with the internalisation of the professional culture, the students began to think about the personal meaning of participation. These reflections

were deeper than thinking about merely participating in the rational incidents of daily practices or experiences. As the following field note shows, these reflections often brought about changes to the students' deepest value systems:

*Todd: we went to the nursing home this week*  
*Researcher: how did that go?*  
*Todd: well it has made me re-evaluate my views on euthanasia*  
*Researcher: do you mean pro or ante euthanasia?*  
*Todd: pro . I mean if I was old and demented and screaming out I want out*  
*Will: oh Todd you are the most [religious] person in the whole world*  
*Researcher: how would you reconcile your beliefs systems with this?*  
*Todd: what [religion] and euthanasia?*  
*Researcher: yes*  
*Todd: well they don't reconcile at all . simple*  
*Researcher: so does that present some tension for you?*  
*Todd: yeah . it certainly gave me something to think about . it was certainly a big learning experience"* (MSIUI 2480 – 2491)

The realities of professional practice were confronting for some students. Their constitution as emerging health professionals often entailed an adversarial relation. It often involved a constant struggle as they battled to deal with the problematic portions of their sense of self that were not in line with those attributes necessary for being a health professional. According to Niemi (1997) individuals must struggle against themselves in order to act according to 'truth'. In this instance the student had come to accept as truth that health professionals should alleviate suffering. Although the idea of euthanasia challenged the students' spiritual convictions he was willing to alter even the most deep seated aspects of his sense of self to shape his emerging professional identity.

The students began to shape their professional identity as they attended more and more to their personal sense of self as they internalised the knowledge,

skills, values and norms of the profession. As the following field note shows, the students began to experiment with aspects of their emerging health professional identity:

*Nurse: [replaces the webster pack in the drawer and pulls out a small bottle of spray] now this [holds it out to the students] can you tell me how long it lasts . they will ask tomorrow . someone told me 6 months after it was opened but I think it's only three months.*

*Bronwyn:is it nitro or isosorbate glyceride you have there? [leans forward to read the label on the bottle]*

*Nurse: its nitro [*

*Bronwyn reaches for her text book*

*Bronwyn:[I will look it up and tell you [flicks through her text book] . I can't find the answer but I know that they say at 4 months you should check it so I think it must be 6 months . but don't quote me on that [laughs] (PSFN: 255-258)*

Professional identity is also referred to as professional self image, public identity, and professional self-concept (Niemi, 1997). These aspects of personal and professional identity emerged as the students acquired new views of self as they learned and adopted the professional role behaviours and attitudes. It was an iterative process that gradually evolved through a process of enacting professional behaviours in ways that conform to the expectations of powerful socialising actions. Professional socialisation theorists (Ibarra, 1999; Niemi, 1997) argue this process eventually leads to students adopting a new professional view of themselves that meets their agents expectations in relation to professional competence.

## INFORMAL PURPOSE OF THE RURAL PLACEMENT

In this section, the analysis focuses on what the undergraduate nursing, medical and pharmacy students understood as the informal purpose of

undertaking the rural placement. For the rural health professionals in this study, high quality health service delivery was dependent on the seamless link between professional practice and their knowledge about the rural community<sup>102</sup>. The rural health practitioners encouraged the students to immerse themselves in community activities as a way of managing their time when dealing with the demands of a busy workplace and students who need quality learning experiences. The students recognised these community immersion activities as an adjunct to the clinical learning experiences. Nevertheless, these informal non-clinical learning experiences were often powerful socialising processes that impacted heavily on the way the students shaped their personal identities.

During the rural placement, the students became aware of the health professionals' expectation they should become familiar with the rural community. Although most of the students were excited to be visiting the rural community, they found their arrival to the rural place a confronting experience, as illustrated by the following field note:

*Todd: well where is it?*  
*Will: well you head up this street and turn right and the surgery is half way along opposite the supermarket*  
*Todd: will we walk man . yeah come on lets walk . then we can get a feel for the place and we can shake off the nerves before we get there*  
*Will: look at that sign – 100 yards . where on earth are we . I mean . like what century is this place working in*  
*Todd: its small town Wilde . that's what they are like (MSFN: 1984-1987)*

Although the community was a physical construct, for the students it was a place that represented a new site of meanings, norms and values. The rural community

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<sup>102</sup> These arguments were developed in chapter 5.



was therefore not simply a new geographical location for the students. It was an informal process of learning and discovery about rural culture that was played out daily as they struggled to give some meaning to situations in the rural community. According to Soja "... the organisation and meaning of space is a product of social translation, transformation and experience" (1989, p 79-80). As such, the rural community was more than another 'setting of interaction' (Giddens 1984) for the students: it was a fundamental constituent of knowledge/power regimes. The students were aware that it was this knowledge that was highly valued by the health professionals. In order to understand rural life the students believed it was necessary to learn more about it.

The rural community was a dynamic space through which the students shaped many conceptions, interpretations, ideas and related feelings about the new physical setting. As the following field interview excerpt shows, the students spent a great deal of time observing rural people going about their daily business:

*"... we are supposed to be getting to know rural people better while we are here. I mean [name] had told us that rural people would know that we would be coming and everything . but [place] is a larger rural area . I haven't found that yet . I haven't been very successful in getting to know the local people . but I will . there are lots of opportunities . we try and go places they will be . like the pub and the supermarket . we have a rotary club meeting to go to"* (PSIF: 525)

According to Thornton & Nardi (1975) informal expectations tend to be implicit and refer to the attitudinal and cognitive features of the socialisation process. The students realised how important the relationship between rural practice and rural community was to the health professionals. The students had

also come to understand the high degree of importance the practitioners had attached to learning about the rural community. As such, the students began to involve themselves into various social activities in the rural community. They set out to learn as much as they could from their observation and interactions with rural people. From these informal, non-clinical learning, experiences the students began to develop a conceptual basis for making decisions about whether they could or could not live in a rural community.

The knowledge the students had about themselves as cultural beings was important for shaping their interest in learning about people in the rural community. As the following field interview shows, the students would often draw upon their experiences and knowledge of social interaction as a frame of reference for understanding certain behaviours they had observed in the rural community:

*"... it's certainly different here . the people are much friendlier . if you walk up the street everyone smiles and says hello . not sure it's me though . I find that its different at home . I mean people just don't look at you when you are walking up the street . you are just another face . but here everybody notices you" (PSUSI: 529)*

For the students in this study, identity and location were inseparable. Questions of 'who we are' are often intimately related to questions of 'where we are' (Bondi 1993, Dixon & Durrheim 2000). These ideas are captured in many geographical studies that focus on the environmental psychological concept of place-identity (Dixon & Durrheim 2000). Many place-identity theories claim that to know oneself is "... an exercise in mapping where one stands" (Keith & Pile, 1993, p 3). So, the idea of being in a different place played a part in causing the

students to think about who they were, how they live their lives and how they think about issues and other people. These reflections on self and others therefore played a powerful role in the way the students shaped their identities. In other words, the student's identities were intimately associated with context. As Pile & Thrift (1995, p. 380) have observed: 'subjectivity and place cannot be separated without foreclosing an understanding of the located subject and the agency and identity of place.'

For many of the students, time in the rural community caused them to reflect on who they were as individuals as members of a collective group. As the following excerpt shows, many of the student's social experiences in the rural community triggered feelings of not belonging:

*"... I hate it here . hate it . just feel so alone . so isolated here . don't want to be here any longer than I have to . this is not me . I don't fit in here . they are so different . even going up the street is awful . they all stare at us . they know we are not from here . this whole experience has made me second guess myself and I thought I was pretty comfortable with who I am"* (NSFN:1409)

The students' talk about not fitting in illustrates the way they constructed cultural boundaries between their own group as outsiders and rural people. People identify with groups they perceive they have some sense of belonging. According to Tajfel & Turner (1986) identification carries two meanings. First, who we are is partly made up of our group memberships at the collective level. This means we think of ourselves in terms of "us" or "them" or "we" versus "they". Second, who we are is partly made up of our group memberships at the individual level. This means at other times we think of ourselves as "I" versus

“he” or “she” or “me” versus “him” or “her”. From these meanings there was a strong tendency for the students to make a simple division between self and other, in-group and out-group, ‘us’ and ‘them;’ these dichotomies are followed in the remainder of this section. The students employed three fundamental frameworks for making these assessments.

First, the students based their identifications on evaluations of socio-economic status. The following field interview shows how the students made collective judgements about people’s social position in terms of wealth, power and professional success:

*“... I don’t think the people are different from anywhere else as such . but I think it is related to class and socioeconomic status . its lower here . people are less educated . they are less motivated to better themselves . there is less interest in entering a profession . they tend to work in factories . shops . farming . when we are not at the surgery or the hospital we like to hit the town and check out the locals . it is so different here . its true what they say about rural . we head up to the pub or to the bakery . I mean just walking up the street is an interesting exercise in learning about the people here” (MSIF: 2785)*

The students made many references to the socio-economic status of rural people, their material possessions and what the students perceived to be a lack of professional drive. These were more than judgements about the socio-economic status of rural people. They were the first category of a ‘typification system’ (Lamont & Molnar, 2002). It was a system the students developed to order and make sense of their own sense of self and social identity. Jenkins (1996) clarifies this relationship by suggesting these are symbolic boundaries that work to define a set of social categories derived from the social recognition that emerges between two groups. The students used these categories to describe

the defining features of “them”, which was the rural other. It became a tacit process of negotiating what defined their own sense of “us”, as in the students, in relation to the defined categories occupied by “them”. Intelligence was one of the most prominent ways the students defined the boundaries between the “us”, and in the process excluded “them”.

Second, the students made collective judgements about the intelligence, and beliefs and values of people who live in rural areas. As the following field note shows, these assessments of intelligence were often negative and portrayed a sense of disdain that took on a derogatory tone:

*“... the people do reinforce the outside perceptions though . the expectations we had about the people . they are you know rural ... you know just the rural . they are scrubberish . they are not too bright . it's just different to what I was expecting . definitely more flannel . yeah more of the flannel . they are rougher round the edges . but that's rural isn't it”* (NSFN: 1679)

As judgments about personal and cultural attributes, these categories provided the clearest expression of group identification. Identity, or a person's sense of self, is the outcome of a developmental process whereby differentiation between Self and Other occurs. Generally, individuals act more favourably towards groups who share with them an important attribute of their identity compared to those who differ significantly on that attribute (Tajfel & Turner, 1986). In the context of this study, the students voiced their own personal characteristics as *“...the brains”* (MSIFI: 2083) and argued that to be a student *“... it helps [to be] intelligent”* (MSIFI: 2083). While the students searched for answers about their sense of self, these were characteristically given with reference to multiple categories of

how they viewed themselves as being smarter and more sophisticated than the typical rural person.

Third, the students made collective judgments about moral boundaries in terms of commitment to family and community values. The following field note shows how the students associated these moral views with the personal integrity of people who live in rural areas:

*"... it's just like everything we have been told about rural from an outside perspective . what we are seeing isn't that different. But at the same time I admire people here . there is a real sense of support. Everybody looks out for everybody else . I really like that . if you lived here that would be a real comfort to know that others are looking out for you"* (NSFN: 1679)

These are moral judgments about rural people. There were other references to the way the rural context was typically characterised by a sense of "... close community values" (MSIFI:2792), and "...strong sense of cohesion" (NSIFI: 1401). The students also commented that "... family is everything" (PSIFI: 525) and "...everyone relies on everyone" (PSIFI: 528) in the "...supportive and nurturing" (MSIFI: 2793) rural community. They are moral judgments that work to define a 'sense of rural community'. The difficulty with these assessments of rurality was the homogenous way in which the students approached them. The degree to which the sense of community exists varies between different communities. It depends on the culture of the rural area and the specific changes in economics and demographics that impact upon sense of community (Findholt, 2006). The explicit purpose of this process of social categorisation was for the students to orientate themselves and make decisions about whether they 'fit' or 'not fit' into this 'rural' group.

For the students, the rural placement appeared to represent a context in which there were multiple and sometimes competing social identities available to them. As the following field note shows, the students began to engage in a process of comparing their own personal belief and value systems to the perceived value systems held by rural people:

*"I live in [place] and they have a very different way of life in [place] . things are done differently . they are different . you know when I compare myself to the people there I can see that I am different to them . I am not sure I fit in here . I don't feel like I belong and I am not sure I want to belong . I have enjoyed the experience but I don't want to stay here"* (NSUSI: 1180)

Throughout the entire rural placement the students, through a process of social interaction, placed their perceived attributes of rural people within particular social categories. These categories were based on their interpretations of ways of rural life, values and attitudes. The students used these to compare and affirm their own ways of life, values and attitudes. Drawing upon classical theories of interaction and identification Jenkins (1996) suggests the way people internalise meanings about others is not the only significant medium of identification. He cites how normative mechanisms, such as shared understandings of social etiquette and accepted ways of behaving, work to emphasise boundaries between "us" and "them". It is a process that gives rise to the possibility that individuals may 'disidentify' with a particular social group (Tajfel 1976, p 44).

The process where the students constantly compared their preferred ways of being to the way they understood rural people to be can be

understood as an evaluative process for social identity formation. The outcome of this evaluative process was most of the students disidentified themselves as rural people:

*"... I am a city girl . I don't belong here . it's just not me . but I am glad I am getting it over and done with . we all have to do a rural placement in case we want to work rural one day . so I am here to experience how it is and to see if I want to be a rural pharmacist . but it's not for me" (PSISL: 703)*

There is a growing body of evidence that shows students' rural background is positively associated with students intentions to work rurally after graduation (Azer et al., 2001; Bushy & Leipert, 2005; Carline et al., 1980; Craig et al., 1993; Fry & Terry, 1995; Laven et al., 2002; Masatoshi et al., 2005; Owen et al., 2007; Playford et al., 2006; Rabinowitz et al., 1999a; Rabinowitz et al., 1999b; Rourke et al., 2005; Smith et al., 2001; Travernier et al., 2003; Ward et al., 2004; Woloshuk et al., 2005; Woloshuk & Tarrant, 2002; Woloshuk & Tarrant, 2004; Wood, 1998).

Although several students in this research identified themselves as having a rural background, and some were even living in rural areas at the time of undertaking this rural placement. Nevertheless, there was only one student that appeared to positively identify as having a sense of belonging to the rural community. The remainder of the students appeared to develop a sense of distinctiveness and disconnection from the rural group. A social identity is "that part of the individual's self-concept which derives from their knowledge of a social group (or groups) together with the value and emotional significance of that membership" (Tajfel, 1981, p 255). Disidentification is therefore not simply the breaking of an identification, but instead, identification with a set of values and



beliefs that are antithetical to those of a group (Hogg & Terry, 2001). These findings suggest that while the students were motivated to pursue not only professional identity goals, but also personal and group-identity goals, and the degree to which both kinds of goals were pursued was shaped by their rural health education experiences. In other words, while the students responded to the clinical component of the rural placement experience with positive identification, the non-clinical components resulted in their disidentification as rural group members.

These patterns of professional identification and rural group disidentification created a cognitive dissonance for the students, particularly when they faced questions from the health practitioners about their intentions to work rurally. As the following excerpt shows, whenever this type of questioning occurred the students tended to indicate they would be willing to consider living and working in the rural community:

*Diversitional therapist: well if you worked in a place like this you could rotate through acute care and aged care . we really need nurses to come and work here . it's really important . we have a lot of trouble getting nurses to stay here*  
*Lil: well I guess that is good aspect of this whole thing . I have come to like aged care . and I like working rural . it has changed my perception about a lot of things . I don't dislike it . last year was just awful . all the patients were loopy and people kept dying . dropping off . but when we came here there is some dementia but most of the staff are friendly and nice [looks up to watch the diversional therapist walk out of the room]*  
*Elizabeth: oh thank god . she . [exhales] I know her whole life story . she is always going on about us coming here to work*  
*Lil: yeah . as if (NSFN: 1602-1605)*

The preference for choosing to work in a particular field or geographic location is likely to be affected by identity considerations, along with

other factors. It seems however that there is some dissonance between students stated intentionality of working rurally and the reality of this career decision.<sup>103</sup> Perhaps the students are telling rural health practitioners and academics they want to work rurally, even when this may not be the case, because of their desire to please these socialising agents. These findings will need further investigation.

## SUMMARY OF FINDINGS IN THIS CHAPTER

A number of arguments were developed in this chapter. These include:

- upon commencing the rural placement the students appeared to be open and willing to participate in a variety of clinical and non-clinical learning experiences and to make changes to their personal and professional identities;
- the students understood the formal purpose of the rural placement as an opportunity to learn and expected to professionally develop as an emerging health professional;
- the socialisation process made three identities available to the students during the rural placement, including:
  - student identity;
  - emerging health professional identity, and
  - rural identity.

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<sup>103</sup> These findings have serious implications for rural health reaching the goal of attracting students to rural practice and are therefore discussed in more detail in chapter 7.

- taking up the student and emerging health professional identities the students moved through three phases of professional socialisation during the rural placement, including:
  - learning the culture;
  - surviving the culture, and
  - internalising the culture.
  
- the students understood the informal purpose of the rural placement as an opportunity to learn about rural people and the rural community and began to compare their own sense of self to the rural other using three frameworks of understanding, including:
  - socio-economic status;
  - intelligence, and
  - family and community values.
  
- the students disidentified with the rural identity and while they learned about rurality they did not appear to internalise the rural belief and value systems as their own.

## CHAPTER 7 DISCUSSION OF FINDINGS

### INTRODUCTION

So far, the findings have shown how the academics and rural health practitioners participating in this study, understand and justify rural health education. They have also discussed the way rural people, places and practice are constructed in their everyday patterns of language use and how students chose to adopt or resist various identities made available to them. There is one final question in this research that is yet to be addressed: *Is rural health education meeting its intended aim as a workforce strategy in terms of instilling in students an interest in a rural career?* In order to address this question, rural health education as a construct is problematised and discussed. The purpose of this chapter is to use hidden curriculum theory to advance theoretical explanations of why rural health education is unlikely to meet its goal of rural health workforce recruitment.

### THE PROBLEMATISATION OF RURAL HEALTH EDUCATION AS A CONSTRUCT

In this study, rural health education has been constructed and positioned as a contested pedagogical space through which undergraduate nursing, medical and pharmacy undergo a transformative process of socialisation and identity formation (chapters 2 to 6). Health science academics appear to understand rural health education as a component of the generalist core curriculum. Rural health

practitioners treat the rural placement as the practical experience for inducting students into the professions. They also see the placement as an opportunity to attract students to rural life and rural practice. Neither academics nor rural health practitioners appear to be treating rural practice reflectively. The rural health education for the students participating in this study was mainly based on practices that privilege generalist professional learning opportunities. These practices were operating in an open system of examination and control.

When the pedagogical space for rural health education is analysed in detail, many disparities and local contestations were evident. Within this space, different groups and individuals—from academics to practitioners to community members to students—appear to construct rural as other. This is one of a number of possible consequences that emerge from their failure to think critically about rural health education. As a construct, rural health education is never fully unpacked or considered explicitly, therefore it is never adequately conceptualised. Until rural health education is seriously addressed as an entity, people will continue to interpret its nature and purpose in different ways.

In order to separate rural health education from this constraining set of practices, there is a need for some description of the complex networks that may have an effect on its practice in undergraduate nursing, medical and pharmacy education. The Foucauldian notion of problematisation<sup>104</sup> of the findings is useful for this task. To achieve this, the findings from the previous two findings

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<sup>104</sup> The notion of problematisation was first discussed on 523 in the introductory chapter.

chapters are deconstructed and reconstructed as problems. The findings suggest that the object to be known in rural health education is professional practice, both generalist practice and rural practice. In order to understand the object of rural practice, it is also necessary to understand the belief and value systems of rural life. In this section, these constructs are problematised according to their relationship to undergraduate nursing, medical and pharmacy education and the rural health education literature.

The issues are significant surrounding the conflicting discourses and practices at this university and for the people who live in the rural community in which this study took place. Only when dialogue is opened in the broader rural health education literature to discuss the significance of such findings can 'transformation' (Foucault, 1984) occur. In this chapter, the problems identified are summarised and linked to previous research undertaken in the field of rural health education. Whenever possible, new research directions are identified. The broad aim of this discussion is to contribute to the development of ongoing evidence-based rural health curriculum that may lead to a stronger rural health system: both in terms of better rural health outcomes and a larger rural health workforce. Two main problems relating to the quality of rural health education can be identified from the findings chapters. These specifically relate to the quality of rural health education, a) as a component of generalist core curriculum and b) as a rural health workforce supply. These problems of rural health education draw attention to the possibilities for creating new ways of

understanding, and therefore exposing students to, rural people, places and practice.

#### *THE QUALITY<sup>105</sup> OF RURAL HEALTH EDUCATION*

A key objective of higher education is the organisation and delivery of high quality curricula that are theoretically informed and evidenced-based models of best practice. The rhetoric of the Australian government is one of providing adequate resources to assist schools of medicine, nursing and pharmacy with the delivery of rural health education. Various Commonwealth programs<sup>106</sup> are now in place to enhance the rural training experiences for undergraduate health science students' and to eventually increase the uptake of rural practice. Although these programs are each slightly different, they are predicated on three factors considered to increase the likelihood of adopting rural practice, namely:

- increased intake of rural origin students health careers,
- increased exposure to rural practice during undergraduate education, and
- increased support of rural teaching.

These programs are not prescriptive and schools are able to implement rural health education in ways that best suit their own circumstances (Ranmuthugala et al. 2007). Nevertheless, as with all undergraduate nursing,

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<sup>105</sup> The term quality is used in the lay sense in this thesis to discuss characteristics that may influence the form and function of rural health education in terms of best practice.

<sup>106</sup> These programs were outlined on page [273](#) of the introductory chapter.

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medical and pharmacy education there is an implicit expectation such teaching and learning programs will be educationally sound and based on rigorous educational principles. The reality for rural health education in this study was something different. Throughout the data analysis it was clear that health science academics, rural health practitioners and undergraduate students each understand and justify their participation in rural health education differently. The consequences of these differing interpretations have significance for the quality of rural health education, both as a component of generalist core curricula and as a rural health workforce strategy.

### **The quality of rural health education as a component of generalist core curriculum**

The undergraduate nursing, medical and pharmacy programs, at the university participating in this research, use a generalist core curriculum to professionally develop students as health professionals. It is a curriculum that is going to become even more embedded in undergraduate health science programs if we are to be guided by the discussions in the broader health science field (Geyman et al., 2000; International Council of Nurses, 2003; Noble et al., 1994). The reason for this growing interest in the generalist core curriculum relates to its efficacy in preparing the future health workforce. It is expected that a generalist core curriculum will prepare students with a broad competence (Noble et al., 1994). By doing so, educationalists expect students will be better prepared to meet the health care needs of people living in communities, ranging from rural to complex suburban and inner city settings (Noble et al.,



1994). These attributes have already been recognised as valuable for preparing students for rural practice (Kamien, 1996; Kamien & Buttfield, 1990; Worley & Lines, 1999; Worley et al., 2000; Worley et al., 2004c).

Generalist core curriculum places greater emphasis on the importance of holistic approaches to health care. The concept, nature and practice of health has undergone significant changes over the past decade. No longer is health care concerned with primarily curing disease and illness but rather focussed on promoting health and wellbeing (Willis & Elmer, 2007). Along with these changing perceptions of health has been a growing dissatisfaction with the biomedical model as a complete strategy for emergent health care needs (Willis & Elmer, 2007). There has been an active shift away from this managerial mode of health care toward greater emphasis on addressing the needs of the population (Willis & Elmer, 2007). Centralising people, rather than management, in health care has given rise to complex and holistic models of care. These values are reflected in professional practice and undergraduate health science education through a focus on 'holistic care' and 'patient-centredness'. Providing students with learning opportunities in actual health care settings allows them to experience how these models of care are implemented in practice (Higgs et al., 2001). For the academics in this research, rural health education, through the rural placement, played a key role in this achieving this objective.

In this study, the academics constructed rural health education as another context from which students could develop competence as emerging

generalist health professionals. The findings of this study show the clinical dimensions of the rural placements did effectively engage students in professional development experiences. Working with health practitioners in actual health care agencies offered the students enriching educational experiences that deepened their understanding of generalist professional practice and health service delivery. At the same time, however, the shortages in the rural health workforce also appeared to be leading to increased pressure on the health practitioners to maintain a service to their patients. These practitioners are already under pressure to meet higher workloads. Asking them to supervise and support students during their rural placements with little onsite support exacerbates this situation.

Busyness permeates rural health care agencies and students experienced all of their learning in this normalised context. The high service delivery workload in the rural context often resulted in the rural health practitioners focussing on tasks to get through the demands of their busy day. They were often forced to find ways of occupying student's time in the health care agency while they concentrated on patients or clients immediate needs. It appears the busy culture of rural practice may give rise to some ideological discrepancy between the value academic programs place on holistic health care, and the necessary task focussed reality of working in the rural context.

Appropriate generalist practice knowledge and skills that value patient centredness and holistic approaches to care cannot be learned by

students if health care agencies do not have enough staff to cope with the busy demands of the workloads. The rural workforce shortages have inadvertently created what Moorhouse (1992) terms the “busyness cult”. Whereas Moorhouse (1992) claims health professionals “... seem to thrive on being seen to be busy; this has been ingrained into their work patterns since their first day on the job” (p 66). In the rural context, busyness did not appear to be arising from a cultural imperative but as a response to dealing with the reality of working in health care agencies that are constantly understaffed, under resourced and constantly dealing with high need clients. The rural health practitioners were therefore inadvertently socialising students into the ‘busyness cult’ mindset.

The rhetoric from universities in general, and schools of nursing, medical and pharmacy in particular, continues to be one of quality higher education. Several Australian universities have developed comprehensive rural health education programs and are now reporting outcomes that suggest students are experiencing high quality learning (Waters et al., 2006; Worley et al., 2004a; Worley et al., 2004b). At the university participating in this study, this rhetoric must be challenged when a snapshot of its rural health education practices reveals an inadequately defined curriculum. Here, the pedagogical space for rural health education is one in which people flounder, and make meaning in different ways. It appears that it is only through the commitment of rural health practitioners that students are having positive and enjoyable professional learning experiences. As a result of the normalised environment of busyness, the

quality of these generalist health professional learning experiences is questionable.

It is clear the busyness of the rural clinical setting is impacting on the adequacy of clinical teaching in the rural setting. Indeed, the broader health science literature reports the increased busyness that health professionals must now deal with is diminishing opportunities for high quality clinical teaching and learning (Charnley, 1999; Forrest et al., 1996). What this study shows is students are 'learning by doing', rather than through critical analysis and reflection. Such conclusions increase the need for rural health practitioners to be better supported in their socialising roles. It has been well established that only when health professionals are sufficiently supported can they facilitate opportunities that will allow students to professionally develop (Marriott et al., 2006; Marriott et al., 2005). For rural health education, this essentially translates to health professionals fostering in students characteristics that will enable their development as generalist health professionals, who may also be willing to work in rural areas.

There is a high probability that in the future even greater numbers of students will be undertaking clinical practice rotations in rural communities. The Australian Commonwealth government is increasing the number of enrolments in undergraduate nursing, medical and pharmacy programs.<sup>107</sup> In the state where this study was undertaken the university is already experiencing difficulties

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<sup>107</sup> See page [2763](#) in chapter 5 for this discussion.

finding clinical practice sites for all undergraduate health science students.

Existing health care agencies that are currently providing placements for students have been used by the university under study for many years. These constraints will most likely lead to greater competition between the schools for placing their students. No doubt, demands for payments, beyond the existing token fees for health professional's contributions to clinical supervision will add to these difficulties. Despite these challenges, there is still a need for universities to provide students with opportunities to learn in health care agencies.

Infiltrating rural health care agencies with greater numbers of students and in greater frequency is likely to occur in the near future. This is likely to exacerbate already heavy workloads and make the work conditions in rural areas even more difficult for rural health practitioners. Without improved preparation and support programs for rural health practitioners who contribute to undergraduate health science education, the quality of students learning in the rural context may be compromised. Greater support for rural health practitioners who contribute to health science education through clinical supervision is one way of improving the quality of these educational experiences. These programs may also contribute to solving the problem of there being no time to adequately address the health needs of rural communities – and also no rural health professionals to provide rural health care. Until these conditions are addressed by universities sending students to rural communities to learn, rural placements are unlikely to provide students with high quality generalist health

professional learning experiences. Nor are these learning experiences likely to promote rural practice as a high quality career option to students. These consequences for rural health education working towards the goal of attracting nursing, medical and pharmacy students to the rural workforce are discussed in the next section.

### **The quality of rural health education as a rural health workforce supply strategy**

Until rural health education starts to disrupt the disabling discourses that are continuing to marginalise rural communities, it is unlikely to fully meet the goal of addressing the rural health workforce shortages. When rural health education is solely constructed as a rural workforce strategy it places the educational purpose of learning in the background and foregrounds a political workforce purpose. This section discusses the way these workforce notions created tension for the health science academics who participated in the study. Understood as a political workforce agenda, rural health education conflicted with the academics main objective of developing students as generalist health professionals. Despite working from an uninformed position, they were trying to incorporate rural health components into their programs by either adapting aspects of the existing generalist curriculum, or re-assigning responsibility for rural health teaching others. Consequently, the body of knowledge known as rural health is not clearly defined and this appears to sustain a hidden curriculum (see below for extended treatment) that works against attracting

students to rural practice.

Making slight alterations to existing generalist teaching and learning activities in undergraduate nursing, medical and pharmacy programs does not qualify as rural health education. In the university participating in this study, there did not appear to be a substantial body of knowledge known as rural health in the undergraduate programs. It is difficult to determine how this finding compares with other universities. This is because most commentators tend to focus on describing the technical or structural dimensions of rural health education. While Bourke et al., (2004) offer some descriptions of rural health as a body of knowledge, they tend to draw upon constructs of rural difference and rural disadvantage. Furthermore, there are no studies reporting how the constructs proposed by Bourke et al. (2004) are used in rural health education programs. Nor are there any studies investigating the effects of using such language, on students learning or intentions to work rurally. Nevertheless, it appears some commentators are beginning to engage in dialogue about the need to establish better organisational structures and processes to guide, resource and implement rural health education (Lyle et al., 2007). Rural health education could therefore benefit from further research that seeks to examine how other discourses might be influencing students learning experiences and future career intentions.

When publishing work, there is a need for rural health educationalists and researchers to provide more depth in their program descriptions.

Rural health, as a body of knowledge, can only be developed, critically analysed, discussed and negotiated when explicit descriptions of curricula content become more visible in the published literature. Academics, rural health practitioners and others who have rural health included in their teaching and learning portfolios will continue to interpret rural health education differently. The academic integrity of rural health education cannot be ensured if teaching staff continue to deliver rural health education from an uninformed position or rely on health professionals who are always busy, and receiving minimal academic support. These are the conditions that will continue to sustain a hidden curriculum in rural health education.

#### THE HIDDEN CURRICULUM IN RURAL HEALTH EDUCATION

Without a well developed, theoretically informed body of knowledge there is a tendency for educationalists to rely on discourses and cultural representations of rural communities that are already in circulation. Within the field of rural health the most prevailing discourses are those relating to difference and disadvantage. Indeed, there are already moves within the field of rural health calling for educationalists to use these constructs in undergraduate education (c.f Bourke, 2004). When ambiguous constructs of rural difference and disadvantage are operationalised at the level of undergraduate nursing, medical and pharmacy education, they can give rise to an unintended set of meanings. This can be understood as a hidden curriculum.



The findings of this study and the literature indicate that health science academics and rural health practitioners are highly committed to rural health education. Rural health practitioners are directly experiencing the pressure and stress associated with working in areas that are understaffed, under resourced and over worked. The need to attract students to the rural workforce is a strong justification for rural health practitioners to support students during their rural placements. Despite this commitment, the language that is used in rural health education does not appear to be constructing rural communities as ideal places to work. It gives rise to a set of meanings that construct rural communities as harsh, isolated, pathologised and risky places to live and work. Several theorists have written about the idea of a hidden curriculum (Friere, 1970; Giroux, 1983; Jackson, 1968; Snyder, 1973; Young, 1971). It is a concept that has been well used within health professional research to show how education often results in the production of unintended as well as intended meanings (Snyder, 1973). Hidden curriculum theorists draw attention to the way these unintended meanings may be at odds with the intended meanings of the official curriculum (Snyder, 1973).

Throughout the rural placement, the rural health practitioners appeared to embrace the notion of encouraging the students to immerse themselves into aspects of rural life. While they understood the rural placement as a key aspect of student's professional development, they also recognised these community-based activities as opportunities to attract students to rural life. These experiences are practical examples of what Ranmuthugala et al. (2007) describes

as 'rural exposure', where students learn the beliefs and values of the rural community. While rural exposure is recognised as an important influence in students' eventual decisions about speciality and practice community (Ranmuthugala et al., 2007), evidence that it increases rural uptake is inconclusive. There are now calls for researchers to identify the particular aspects of rural exposure that results in a favourable attitude towards rural practice, thereby influencing students to return to rural areas (Ranmuthugala et al., 2007).

At present, the more optimistic perspectives of rural life and culture seem to be overshadowed by discourses of rural deficit that students are exposed to at all levels of the studies. Constructing rural communities as the medicalised other that are pathological and risky places, may be contributing to their ongoing marginalisation. Sociologists have shown the social exclusion of certain populations in society does not simply result from poverty, inequitable access to and accessibility of services. It is a multileveled process in which particular groups are othered, and this invariably leads to social division. Some theorists argue that othering sets up two binary categories, being 'us' and 'them' (Butler, 1993; Mouffe, 2000). These binary categories emphasise difference over similarity and ignore what people share, in favour of what divides them. The findings generated by this research show the students tended to use these categories to make sense of their relationship with rural communities. The students appeared to use their experiences of rural exposure to constant evaluating whether they fit or not fit in the rural context by using these categories of 'us' and 'them'.

The positive dimensions of rural exposure seem to be hampered by limited contributions rural health practitioners can make to health science education in the rural context. Rural practice is extremely busy and legal requirements often require sole practitioners to remain on site in many health care agencies. This means that while students are being immersed into aspects of rural life, they are often doing so alone. As such, the students are left to form their own interpretations about rural life and rural culture. In this study, the students often appeared to use notions of rural deficit to make sense of their experiences. In other words, for the students “us” was an identity characterised by intelligence, drive, and ambition, while the rural “them” was an identity marked by sub-intelligence, complacency and roughness. As the findings chapters (5 and 6) show rural exposure, organised within ambiguous discourses of rural difference and disadvantage (understandings of rural deficit) are unlikely to be conducive to attracting students to rural life. There are, however, many possibilities for transformation in rural health education.

Immersing students into rural culture has the potential to be an enabling feature of the rural placement to attract students to rural practice and rural life. There are many positive aspects that rural exposure can offer students. There are many chances for students to meet people, develop relationships, and understand rural culture in healthy and positive ways. In this study, rural exposure provided students with many situations that challenged the notions being sustained in the hidden curriculum in rural health education. Rural

placements can therefore play an important role in exposing students to alternative ways of thinking about rural people, places and practices in deficit ways. Foucault's (1980) writings on education and subjugated knowledge (see below for this discussion) can contribute to the way rural health education can be positively developed.

Language used about rural people, places and practice in the pedagogical space for rural health education had overtones that were, at times, derogatory demeaning, objectifying, and denigrating. Discourses, even those which are unintended, such as the rural ordeal of living and working in a harsh and isolated rural community where people are subintelligent are not helpful. This othering of rural communities appeared to be normalised in the practice of rural health education at this university. The use of descriptors in the discourses both written and verbal by health science academics, published rural health education literature, rural health practitioners, students and lay community members are unintentionally characterised by judgmental tones, inaccurate stereotypes, opinions, and derogatory connotations. It is a use of language that contravenes ethical and professional approaches in education. Furthermore, the language used to talk about rurality does not always reflect the principles of ethical conduct, nor the competencies expected in professional practice, across all health disciplines (Australian Nursing and Midwifery Council, 2006a; Australian Nursing and Midwifery Council, 2006b; Pharmaceutical Society of Australia, 2003).

There are several options of dealing with a hidden curriculum. First, what one does with a hidden curriculum depends on whom it is hidden from. Martin asserts "... we can do nothing; we can leave the setting alone rather than try to change it" (1994, p 144). This suggests the need to do something with a hidden curriculum only arises if it is hidden from the learners themselves. Gordon (1988) opposes this response by arguing it suggests that other persons, such as sociologists, bureaucrats and teachers simply do not matter in this regard. In this research the hidden curriculum is impacting upon the way learners construct meanings about rural people, populations and practice as well as influencing the way they shape their personal and professional identities. These identities may not be conducive to the political imperative of increasing the future rural workforce supply. These findings suggest that doing nothing is not a reasonable response to the identification of the hidden curriculum in rural health education.

Second, a discovered hidden curriculum invites response only if it is an undesirable one. Martin states, "if a hidden curriculum is harmless, what we do with it will not matter very much" (1994, p 145). The qualities within the hidden curriculum in rural health education are undesirable for advancing the goals of rural workforce supply and may also be perpetuating relations of difference between rural and urban populations. These findings indicate a response to the hidden curriculum is necessary and as such overrides Martins (1994) third possible action of simply abolishing a setting, instead of trying to change it. With some minor changes it may be possible to emphasise the positive attributes of

rural health education and capitalise on the enabling aspects of rural exposure.

One potential way of responding to the hidden curriculum is for educationalists and researchers to formulate new and additional ways of defining rural health education. Rural health education is currently defined by policy makers, researchers and educationalists as a rural workforce supply strategy. It is a definition at odds with the way it is being implemented in undergraduate nursing, pharmacy and medical programs as a pedagogical opportunity for students to learn about clinical and professional practice. Rather than defining rural health education as a rural workforce supply strategy it may be time to reconceptualise it as a socialising educational process. In redefining rural health education as a socialising process it is possible for academics to recognise its influence on the ways students shape their personal and professional identities.

Fourth, Martin (1994) argues that it is always possible that some researchers will want to embrace rather than abolish the hidden curriculum that was found. While the findings of this research suggest that educationalists should not embrace the hidden curriculum that exists in rural health education there may be opportunities to use our knowledge of its presence to disrupt the discourses that are being reproduced through it. It is time for rural health education to be subjected to the same educational rigours for curriculum development that other pedagogical interventions in undergraduate nursing, pharmacy and medicine must endure. This will require

educationalists to be explicit about the learning objectives and anticipated learning outcomes for the rural health education curriculum.

Contemporary approaches to educating undergraduate nursing, medical and pharmacy students reflect the influence of constructivist perspectives to learning and teaching and more recently, socio-cultural cognition (Putnam & Borko, 2000). Such perspectives have led to the identification of dimensions of professional practice or hypothetical representations of it, through case studies and problem based scenarios, for example, as the favoured site for learning knowledge about being a health professional. Other contemporary approaches also emphasise the importance of experience for learning about professional practice and professionally developing as a health professional.

In recent years, reflection and critical analysis have emerged as key concepts for personal and professional development. These approaches incorporate a myriad of activities that may be beneficial for the practice of rural health education, including, critical incidents, action research, reflective practice and critical thinking. Each of these activities are characterised by different interpretations that draw upon different values – what Gore (1993, p. 152) and Foucault (1980), refer to as “regimes of truth.” Reflection and critical thinking does not always mean the same thing across different disciplines. Nevertheless, these approaches are suggested as being potentially useful for creating subjugated knowledge, harnessing the marginality of rural communities and rural health and producing an environment in rural health education

which integrates diversity as a more realistic option than is currently being constructed in the educational context in this study.

Rural health education can play a role in disrupting the disabling discourses of rural deficit in undergraduate nursing, medical and pharmacy programs. Health science academics and rural health practitioners, as important socialising agents in rural health education, are capable of using their relative autonomy to develop educational practices that embrace enabling discourses for rural health. This process involves developing a critical consciousness, which will in turn inform the basis for their political action. Such critical perspective in rural health education can only be achieved in dialogue with others.

One of the many possible starting points for disrupting disabling discourses in rural health education is the lived experience of students. It is this dimension of rural exposure that is so important. The findings generated in this study show that rural exposure often presented students with situations that conflicted with negative constructs of rural people, places or practice. These are important opportunities for students to develop 'subjugated knowledges', 'derived from dangerous memories of history that have been suppressed and information that has been disqualified by social and academic gatekeepers' (Kincheloe & Steinberg, 1997:45). These forms of educational and social practice involve students in a process of re-negotiating their personal and professional identity formation.



Within the academic units under study, there was an expectation that students develop competence in interpersonal skills and self-reflection. A core component of reflective practice is the ability to identify and challenge self-evident truths, seek new understandings and use this knowledge for professional development. In practice, however, such critical interrogation about personal and professional development rarely took place. Indeed, health science curricula in general has been criticised for not providing students with critical reflective opportunities (Coles et al 1990). The undergraduate nursing, medical and pharmacy programs at the participating university have managed to make some inroads into this area through problem- and case-based learning, and work integrated learning programs and rural health education is a good example of this. There is evidence that these types of teaching and learning activities will produce positive outcomes in terms of students' personal and professional development (Waters et al., 2006; Worley et al., 2004a; Worley & Lines, 1999; Worley et al., 2004b; Worley et al., 2004c). The findings in this research place emphasis on the active role of the students in their learning experiences, the way they elaborate information and use these meanings to construct their personal and professional identities.

Undergraduate students are undergoing a transition in terms of their professional identity formation. They can be described as being in a state of 'moratorium' (Marcia 1966), which is a state of active exploration without commitment so far. Moratorium is more commonly understood as a temporary

delay or suspension of activity (Collins Dictionary, 1981). Student identity can therefore be understood as being in a state of suspended possibility. Rural exposure presents them with the opportunity to examine their personal and professional identity and make changes to it. These changes to students' identity formation may be linked to the decisions about future career planning.

The findings reported in this study show students display cognitive integrative complexity and experiential orientation. In other words, the students were all open to the possibility of shaping their personal and professional identities. They were not only curious about, but sought personal meaning, for their rural learning experiences. The uncontested meanings the students tended to construct about rural communities were most organised within the discourses in circulation in rural health education, namely deficit, ordeal and idyll. These discourses appear to be constraining the ability for rural health education to achieve its rural health workforce agenda.

From the findings generated in this study several provocative hypotheses and questions emerge. One of the prevailing public discourses in circulation in rural health is that rurality (which the students in this study interpreted as rural place, community, people and practice) is in many ways different. Rural is not simply a setting, but rather one of many social constructs (ie. the range of social relationships and social processes associated with rural environments) (Thurston & Meadows 2003) that informs students' experiences. The ambiguous emphasis on difference not only casts rural places as homogenous entities, but in

health science education, also tends to speak to a difficult environment (Wakerman, 2004) that is a risk factor to health and wellbeing (Thurston & Meadows, 2003a). In rural health education, rural difference tends to be defined in terms of poorer health status, unequal access to health and other social services, and severe health workforce shortages. Why would any new graduate seek a career in a context that is already under-resourced, over-burdened and expected to face worsening conditions over the next ten years? Students' vocational decisions are driven by many different influences, such as family, education and media.

Perhaps it is time for the field of rural health education to recast the focus on student's decisions about rural workforce intentionality into the context of identity formation. This research shows rural health education to be a critical period of professional development for students in their undergraduate program. It is also an intensive period in which students synthesise notions of personal sameness and difference in a process of definition of self as they interact with the rural community. At the same time, commitment to a particular field of work, such as rural practice, could be an important outcome of this process; the nexus for one's personal and professional identity is intrinsically related to this decision. Career preferences are complex decisions that emerge from multiple determinants. The pursuit of a rural career that appears to be incompatible or appears to be markedly different from a student's personal identity is unlikely.



## CHAPTER 8 CONCLUDING THE RESEARCH

### INTRODUCTION

In concluding this qualitative study, it is timely to discuss the research process and the nature of the research findings as outcomes of that process. Through intensive fieldwork, the research process involved an array of people, places, voices, and perspectives in ways that have not previously been considered in the field of rural health education. It is a style of research that "... can be understood as a series of ... conversations and interactions with informants and significant others; particular places; ideas; and self" (Coffey 1999, p. 159). The study was interested in the role of professional, institutional, social and personal relationships in teaching and learning rural health education. The purpose of this chapter is to provide conclusions relating to the practice of rural health education in undergraduate nursing, medical and pharmacy education. Following a summary of the thesis, the way the study achieved the research aims and answered the research questions is presented. The strengths and limitations of the research approach are then outlined, and future directions and recommendations for improving the quality and integrity of rural health education are provided.

### SUMMARY OF THE THESIS

Rural health education was examined in this study, as a process of professional socialisation and identity formation. This represents a

departure from the way rural health education is mainly understood and studied as a rural health workforce supply strategy, as chapter 2 showed. As well as situating the study in existing knowledge, the analysis of the literature shows how language of rural difference and disadvantage is used in vague ways. Although these discourses have proven to be highly effective for attracting scarce resources to the field, they construct rural health within a deficit model and obscure other ways of knowing rural communities. One reason for this obscurity is the voices of academics, health professionals, undergraduate students and rural community members are not very audible in the published literature. These are central actors in the practice of rural health education therefore their experiences represented a key gap in knowledge, in which this study sought to make inroads.

Health science academics, rural health practitioners and undergraduate nursing, medical and pharmacy students were invited to participate in this study of rural health education in operation. Data were collected through a review of published rural health education literature, fieldwork (including curriculum document collection, observation-of-participation during rural placement, field notes, field interviews and a reflexive diary) and a series of semi-structured interviews key informants. Data were collected between June 2005 – December 2005. This was determined by the time period and dates scheduled for each of the rural placements and participants availability for interviews. The procedures for data collection and subsequent analysis were embedded within the need to

engage the participants in a process of interpretation and reinterpretation of data as it were collected. This was consistent with the underlying principles of critical discourse analysis (Fairclough, 1992) and qualitative research (Denzin & Lincoln, 2006).

By focusing on language used by academics, health professionals and students a methodological approach, using discourse (Foucault, 1972; Foucault, 1973; Foucault, 1975), power (Foucault, 1972; Foucault, 1973; Foucault, 1975) and identity (Hall, 1996; Tajfel, 1978; Tajfel & Turner, 1986) was used to analyse instances of discourse. Key themes arising from a critical discourse analysis (Fairclough, 1989, 2001; 1992; 1995b; 2003) to the analysis of literature, curriculum documents, and field data were used as the basis of interpretation of the interviews. As a whole, the data were analysed thematically in terms of their multiple discourses to explicate the overt and hidden curricula and pedagogies operationalised by the participants. The findings generated by the analysis participants' use of language in rural health education are particularly illuminating and provide new insights to the field. Participants' choices about teaching, learning and pedagogy were closely connected with their beliefs, values as ideas about students' learning and the varied interpretation of the rural health education curriculum.

The research concludes the pedagogical space for rural health education is a contested site to which different groups enact their ideological sense of agency to shape the meaning and identity-forming experiences of

undergraduate nursing, pharmacy and medical students. This was a process understood as professional socialisation. Whether rural health education is constructed as a rural health workforce supply strategy or a set of teaching and learning activities for a generalist core curriculum in health science education, its practice might benefit from greater critical awareness at all levels. For this reason it is important the research aims and questions are scrutinised to determine the extent to which they have been answered by the findings in this research.

## ACHIEVING THE RESEARCH AIMS AND ANSWERING THE RESEARCH QUESTIONS

The purpose of this study was to develop a research framework to describe and interpret how academics, health professionals and undergraduate nursing, pharmacy and medical students produce and made sense of different social semiotic meanings in rural health education and consider how students' identities were shaped by these influences. Five research aims and questions emanated from the purpose of the study. These were shaped and moulded as the research unfolded. The research aims, questions, and the answers generated in this study, are presented in this section.

### **Research Aim 1**

The study aimed to examine the ways various groups construct rural health education in different institutional and cultural spaces. The first way it achieved this was by examining the published literature on rural health education. The literature review served a greater purpose than



situating this study in the research context. The literature was treated as a source of data for examining how rural health education is constructed by government, rural health researchers and educationalists. The first research question was designed to reflect this task. *How is rural health education constructed within the rural health literature?*

Within the published literature rural health education is predominately constructed by researchers, educationalists and government as a rural health workforce supply strategy. It is a strategy that relies on the expectation that students will acquire an interest in rural practice through rural learning experiences. These rural learning experiences are taking place within a field that constructs rural communities as different and disadvantaged. There is an emphasis on the harshness, isolation and difficulties rural people are experiencing accessing health and social services (Bourke et al., 2004). Such constructs appear to have generated a sense of urgency for responding to the rural condition, which is understood as being in a crisis state (Wearne & Wakerman, 2004).

There is an expectation that rural health education will attract new graduates to rural practice, which will in turn strengthen and maintain the rural health workforce. A stronger rural health workforce is expected to lead to better health outcomes for rural communities (Australian Health Minister's Conference, 1994; Australian Health Ministers' Conference, 1996; Australian Health Ministers' Conference, 1994; Australian Health Ministers' Conference, 1996;

Australian Health Ministers' Conference, 1999; Australian Health Ministers' Conference, 2003). Despite the enthusiasm that educationalists and researchers show for addressing the rural health workforce shortages, there has been little work published on the concepts and constructs that underpin the definitions of rural health or other important pedagogical factors.

A great deal of what is being reported in rural health education can be understood at a theoretical level using concepts of professional socialisation and professional identity formation. Indeed, one of the key roles of university faculty members is to teach, advise and socialise students into the dual cultures of university life (Tierney, 1988; Tierney, 1997) and their chosen health discipline (Clouder, 2003b; Niemi, 1997). Theorising rural health education as a process of socialisation was a way of encompassing the way health science academics and rural health practitioners, who contribute to students' clinical learning experiences, might shape the pedagogical space for rural health education. The way health science academics and practitioners talk about the rural health component of their academic units was therefore treated as the second source of data for examining how rural health education is appropriated in the undergraduate programs. The second research question reflected this task. *How do academic and health professionals understand rural health education in the undergraduate nursing, medical and pharmacy curriculum?*

It appears the health science academics participating in this study hold a different understanding of rural health education than how it is

constructed as a rural health workforce supply strategy in the literature. Instead, they understand rural health education as another component of the generalist core curriculum. While rural health is not their primary focus in the undergraduate nursing, medical and pharmacy programs, they seem to have a desultory commitment to rural health education.

Although the academics seem to be doing their best to incorporate rural health content into their teaching programs, they are doing so from an uninformed position. The outcome of these attempts is some modification to the existing generalist core curriculum to accommodate a rural dimension: there does not appear to be a body of knowledge known as rural health in the undergraduate nursing, medical and pharmacy programs at the university under study. This suggests that while academics are paying lip service to rural health education, it is being implemented in a way that will be unlikely to be sustained should staff movements, or changes to the funding processes supporting such activities occur.

The academics rely heavily on external teaching staff and rural health practitioners for teaching students about rural health. The practitioners that supervised students during their rural placements also viewed the purpose of the rural placement as a component of generalist health professional curricula. They predominately engaged students in clinical learning experiences and invested a great deal of their time professionally developing students as generalist health professionals. At the same time, they placed equal value on immersing

students into rural community in order to experience aspects of rural life. Others term these experiences as 'rural exposure' (Ranmuthugala et al., 2007) and call for researchers to be more explicit about the nature of these activities. These community immersion activities were not only a way of alleviating the pressures associated with dealing with the busyness of the work place, which was compounded by the student's presence. They were designed as part of a strategy to sell rural practice to students as a positive career option.

During the rural placement, the reality of rurality seems to be imposed on students through community immersion activities. Chapters 5 and 6 argue, however, that these immersion activities are socially constructed and contrived in themselves. Consequently, these 'rural exposure' activities are a social construction being used by rural health practitioners to advance the particular purpose of rural workforce recruitment. Overall, the rural health practitioners did not construct their rural communities as different and disadvantaged, unless they were engaging in strategic planning for attracting scarce resources to their community. Instead, they seem to understand their rural community as a healthy and thriving place that offers many opportunities for students to grow and develop both professionally and personally. By encouraging the students to explore the rural community and speak with rural people, the practitioners expected the students to recognise these opportunities for personal and professional growth.

## **Research Aim 2**

The study aimed to describe and interpret the cultural representations of rural communities being produced and reproduced within the day-to-day practice of rural health education. It first achieved this by examining the curriculum documents for the academic units in which rural health education now features in the undergraduate nursing, medical, and pharmacy programs. It also achieved this by specifically examining the way academics and practitioners spoke about rural communities in their talk about rural health education. This was reflected by the third research question. *How do academics and health professionals use their understandings of rural health education to shape their teaching practices of rural health education?*

Without a sufficiently well developed body of knowledge known as rural health in the undergraduate nursing, medical and pharmacy programs the health science academics talk about rural communities was often from an uninformed position. It was talk that created the conditions for a hidden curriculum to emerge, which cast rural communities as backwater and risky places. The academics tend to use language of rural difference and disadvantage, not only in terms of the health status of rural people and their access to health care services but, as a general episteme. It was a finding that demonstrates the way in which popular representations reproduce constructions of rural communities in terms of the problems they are facing.

Over the last decade there has been increased ‘medicalisation’ of rural people’s lives, that is an increase in the medical profession’s

intervention in the normal workings of rural communities. It now seems that every aspect of rural communities appears to have become the focus of 'medical gaze' (Foucault 1973) and made a potential problem in rural health education. As medicalisation has become so ingrained in society, rural health professionals themselves have become participants in reproducing these discourses. Not as a representation of the reality of rural life but as a strategic and political means for attracting resources to their communities. Although the medicalisation of rural communities may be an effective discourse for use at the political level, when used as the pedagogical basis in rural health education it is at risk of being inadvertently used as a way of regulating and restraining rural communities. It is this hidden dimension of power that contributes to the power imbalance between rural and urban communities and may therefore contribute to the ongoing marginalisation of rural communities.

Intertwined with medicalisation in the health science academics talk about rural communities was the concept of 'othering'. Language was used by the health science academics in several ways to define rural communities by what they are not in relation to dominant urban understandings. As the majority of undergraduate nursing, medical and pharmacy education takes place in urban and large regional settings academics tended to view the urban values and beliefs as the norm, with any perceived deviations from these accepted norms, such as poorer health status, being viewed as being prone to weakness. Without a formal body of knowledge known as rural health in the academic programs,

the academics tended to rely on the discourses of difference and disadvantage to talk about rural communities. In language used to prepare students for their rural placements, these discourses unintentionally constructed rural communities as pathological, harsh and dangerous entities. Undertaking the rural placement in a rural community was therefore constructed as a rural ordeal.

It was within these rural deficit understandings of rural communities the health professionals, and to a lesser degree health science academics, were trying to sell rural practice as a viable career option to students. Selling rural practice involved emphasising the positive attributes of living in a rural community. With a limited understanding what life and work is like in the rural setting the academics tended to rely on constructing rural communities as 'peaceful, wholesome, tight-knit, caring, timeless' (Little, 1999). These discourses, which can be understood as the rural idyll, are just another myth that constructs rural people and places in simplistic, unrealistic and idealised ways (Little, 1999; Yarwood, 2005). Promoting rural practice in positive and idyllic ways is not necessarily wrong; it just provides students, who must engage with these representations at a variety of complex levels during the rural placement, with certain pre-readings of rurality.

By immersing the students into the rural community culture during the rural placement, the health professionals created this multileveled nature of relationships. It was a teaching and learning arrangement, in which the product, purpose and outcomes of rural health education emerged from the

interaction connections between the rural community as a complex system and the students. Through these experiences the students were introduced to alternative discourses for understanding rural communities as healthy, connected, supportive and thriving. Nevertheless, there were also instances of language use by rural community members that sustained the hidden curriculum during the rural placement. These instances of interaction worked to sustain and legitimise the notion that rural communities are different and disadvantaged. The meanings produced and reproduced in the pedagogical space for rural health education shaped the way students formed their personal and professional identities.

### **Research Aim 3**

The study considered how students' identities are enmeshed in the relations of power and knowledge that shape rural health education as a pedagogical space. These components of the analysis were based on the data collected from the observations of students during their rural placements and their talk during formal and informal interviews about those experiences. The analysis of the boundaries between perceived similarities and differences between lay and professional, and rural and urban groups, were therefore at once an analysis of student's identity formation. This analytic task was reflected in the fourth research question: *How does rural health education shape undergraduate nursing, pharmacy and medical students' personal and professional identity?*



Although human experience is complex and integrated, the rural placement appeared to include clinical and non-clinical learning experiences for the students. The clinical learning opportunities allowed the students to develop competence in their knowledge, skills and attitudes in actual health care agencies. It was a complex process of professional socialisation is a complex process by which the students learned and acquired the knowledge, skills and sense of identity that are characteristic of a member of their particular profession. The end product of the clinical learning experiences was some internalisation of values into the student's self image: in other words the development of a professional identity.

The non clinical learning opportunities allowed the students to learn about rural place as a space invested with understandings of behavioural appropriateness and cultural expectations. The community immersion activities provided the students with opportunities to negotiate the complex symbolic boundaries that exist between urban communities and rural communities. Through their social interactions with rural community members the students tended to construct various social categories that related to their interpretations of rural ways of life, values and attitudes. These constructs highlighted the boundaries between notions of 'them' and 'us', from which the students engaged in a process of social comparison between self and other. The students appeared to be at ease within this model of rural health education. Nevertheless, they appeared to construct their identities in ways that are fundamentally different to

what they perceive as a rural identity.

#### **Research Aim 4**

The study aimed to explain how these relations between meanings and practices in the pedagogical space have implication for the realisation of the implicit goals of the rural health education agenda. It achieved this by drawing upon the findings of the study to discuss what the different ways of constructing rural health education might mean for the field of rural health education. *What are the implications of this for how well rural health education is meeting its intended aim of instilling in students an interest in a rural career?*

One of the main objectives of this study was to determine whether rural health education is achieving its aim of generating student's interest in working rurally. Research findings from this thesis suggest that rural health education has the potential to positively impact on undergraduate nursing, medical and pharmacy student's rural career decisions, although more critical work needs to be done. There is now a comprehensive infrastructure in place to support rural health teaching and learning, both in the classroom and rural community context. Commonwealth funding is now available to Schools of Medicine and Pharmacy as an incentive to incorporate rural learning experiences. In the context of this study, all the participating health science academics were aware of the difficulties associated with health workforce shortages. The medical and pharmacy academics were particularly open to the notion of incorporating rural health content in their teaching and learning portfolios. Perhaps if the same

funding arrangement were available to Schools of Nursing, this level of commitment to rural health teaching could be reached by nurse academics.

Rural health education can be considered as a process of professional socialisation that influences the way students construct their personal and professional identities. Identity has been linked with career decisions. With some work, rural health education has the potential of meeting its intended aim of instilling in students an interest in a rural career. The academics participating in this study appear to be in need of better resources to assist them with rural health curriculum design and implementation. The rural health professionals participating in this study are extremely accommodating and supportive of facilitating students learning in the rural community setting. At the same time, however, this appeared to be a difficult time for the health professionals, who were already struggling with the effects of the workforce shortages without the additional demands of working with students.

At present, the discourses of rural deficit that are in circulation appear to be constraining the ability for rural health education to reach its goal of generating students' interest in rural practice. The point being offered in this research is that traditional knowledge frames, such as notions of disadvantage, isolation, and harshness are too rigid and exclusive in their categorisation. There is a need to find alternative ways to represent rural place and the plurality of positions they make available to students. This is reliant on more theoretically applied and critical research for interrogating the influential effects of

language use in rural health education. Once again, the potential for rural health education to develop in this area is rich. There is already an experienced and diverse group of researchers and educationalists who are committed to improving rural health education in order to improve the conditions for rural communities. By refocussing the current preoccupation with measuring students' claims of rural intentionality to greater emphasis on the socialising effects or students' identity formation in rural health education new discourses can be constructed.

### **Research Aim 5**

The study aimed to examine how the construction processes that both produce and are reproduced by rural health education might be conceptualised and analysed. It achieved this by using the concepts of boundaries and contested pedagogical space to theorise rural health education as a process of professional socialisation and identity formation. The conceptual framework was useful for critically investigating rural health education as a process of professional socialisation and student's identity formation by concentrating on interaction in various social, political, professional and educational contexts.

Examining the relationship between the linguistic practices in rural health education was highly complex and a difficult task to do in practice. Not only was it challenging to translate this into research questions, it was difficult to navigate the complex and slippery theories of discourse, power and identity that were necessary components of using professional socialisation as the

theoretical framework. Initially, it was anticipated that Fairclough's (1992) techniques and tools for analysing real instances of talk and texts would provide a sufficient research framework. The rationale for this assumption related to it being a textually oriented approach to critical discourse analysis that unites linguistic and social theories of discourse (Fairclough, 1989, 2001; Fairclough, 1992).

It soon became apparent that critical discourse analysis is an approach that requires indepth knowledge of other theories, such as power (1972; 1973; 1975; 1978; 1988b; 1994) discourse and identity (Hall, 1996). This could only be achieved through the comprehensive conceptual and theoretical research framework that had been developed, as outlined in chapter 3. Only when this was developed, was it possible to identify the particular tools and techniques of Fairclough's linguistic and social analysis that were useful for analysing the key features of language use in rural health education.

The conceptual and theoretical framework developed in chapter 3 was useful for studying rural health education as a pedagogical space to which governments, researchers, academics, health professionals and students act to shape the educational content, processes, and outcomes. Each of these groups were understood as having their own agency in rural health education whereby their beliefs, values and ideas create the meaning and identity-forming experiences of undergraduate nursing, pharmacy and medical school learning for students. In this study, rural health education was understood as a

contested pedagogical space, where undergraduate students are socialised as health professionals and develop their identities. This new way of understanding rural health education allowed new questions about its practices and outcomes to be asked. The research questions extended the inquiry beyond the focus on rural health workforce outcomes to instead concentrate on academics, health professionals and undergraduate nursing, pharmacy and medical students lived experiences of rural health education. Developing a new conceptual and theoretical that could analyse the different and complex aspects of rural health education in practice was a major achievement of the study purpose.

The analytic techniques chosen from Fairclough's critical discourse analysis methods coalesced well with the social constructionist – critical framework used in this study. Faircough's approach to critical discourse analysis (1989, 2001; 1991), Foucault's writings on power, discourse and identity (1972; 1978) and Berger & Luckman's (1966) writings on social constructionism are all premised on the understanding that social reality is nothing more than socially constructed interpretations. Furthermore, these theoretical perspectives all share a concern with patterns of social meaning encoded in language (known as discourse in this study). The critical epistemology used in the research was useful for judging the truth claims inherent in the discourses that were encoded in the language used by individuals participating in rural health education.

The researcher is centrally positioned in qualitative research. This positioning and the application of power, discourse, identity and

socialisation theories placed the study at risk of bias through a priori knowledge and assumptions. Bias, in qualitative research, has a slightly different meaning and is dealt with in a different way from quantitative research (Elder & Miller, 1995). To combat this risk, the critical discourse analysis was not approached as a descriptive or explanatory practice that aimed at truth claims.

The critical discourse analysis was approached as a form of reflexive research. "Discourse analysts understand the task of research to be a reflexive and productive not a descriptive practice" (Parker, 1992:6). From this reflexive orientation, the use and application of theory in the analysis was explicit. The aim of the critical discourse analysis was not concerned with describing and explaining the world, or in making truth claims. Instead it aimed to account for how particular conceptions of the social world have become fixed and pass as truth in the appropriation and practice of rural health education. Seeing how the effects of truth are produced in discourses cannot be presented as truth because discourses "... themselves are neither true nor false" (Foucault, 1984b: 88).

The findings produced in this research are interpretations that have emerged throughout the research process. As such, the criteria for evaluating the validity of these qualitative research findings are trustworthiness and authenticity. The study achieved these in several ways. First, through the use of a tested research method. Second, through the triangulation of multiple sources of data. Third, through having the research participants check and corroborate the findings by obtaining their feedback through informal interviews.

Fourth, through a research adviser who was outside the immediate supervision team. These strategies were used to make the findings robust and authentic.

When rural health education is recognised as a dynamic, context dependent and ever changing pedagogical intervention the significance of the temporal boundaries of these findings are magnified. The discourses identified in this study were highly influential on the ways academics, health professionals and students behaved in rural health education. It is important to emphasise that this occurred at a particular moment in time. Even as this thesis is being prepared for completion, the political, social, professional and educational contexts are changing. Of particular significance, is the election of a new government, the introduction of a new medical curriculum and staff changes. It is crucial to emphasise that new discursive tensions will result from these changes for the practice of rural health education however their discursive effects will be delayed. It will be equally important for researchers to identify other key events, documents and practices and select other discourses to subject these data sources to similar analytic scrutiny that has been described in this thesis.

## STRENGTHS OF THE RESEARCH APPROACH

The research used a qualitative research design because this offered opportunities to observe, listen, question and interpret the significance of health science academics, rural health practitioners and undergraduate nursing, medical and pharmacy student's experiences of rural health education. It was an account of power that acknowledged agency, culture, structure and



the role played by particular representations of 'truth and knowledge' (Foucault, 1972). These concerns imply the recognition that all knowledge, particularly in reference to an ever-changing and dynamic social context, is culturally, historically, and contextually bound (Gergen 1985). As such, this study extended into the social, political, and cultural realms for a deep understanding of the present reality of the practice and outcomes of rural health education. From this design, five main strengths of the research outlined in this section include:

- human experience and interpretation through social constructionist perspectives;
- language use and the production and reproduction of discourse analysed through techniques of discourse analysis;
- the effects of power and ideology in the everyday practice of rural health education through a critical perspective;
- identity as an outcome of the socialising process of rural health education, and
- rural health education as a way of achieving emancipation through the use of critical and reflexive perspective in its pedagogical work.

**The study of human experience and interpretation through social constructionist perspectives**

As was clear in chapter 3, in the consideration of social constructionism<sup>108</sup> knowledge is the result of human thought and social interaction. Knowledge is therefore socially constructed. This was an important notion for this study of the way different groups construe rural people, places and practice in rural health education. Ways in which people construe the social world of rurality influences their interpretation of the experiences of rural health education. One strength of this study was the use of social constructionist perspective as a way of acknowledging and therefore considering the ways people know, understand, experience and talk about and during rural health education. The findings generated from this position offer the field of rural health education new descriptive and meaningful accounts of academics, practitioners and students accounts of rural health education in their own words. The findings of this study make a useful contribution the field because they create possibilities for developing educationally sound and theoretically informed constructs and concepts for rural health education that may work towards the goal of rural workforce recruitment.

**The study of language use and the production and reproduction of discourse through techniques of discourse analysis**

A second strength of the study was the strong theoretical basis pertaining to language use, and the production and reproduction of discourse, from which the research framework was developed. Social constructionist perspective

<sup>108</sup> Social constructionism was discussed on pages ~~17231733531723~~

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emphasises the way knowledge and experience is historically, socially, and temporally located. These core features of social constructionism informed the decision to theorise rural health education as a process of socialisation-as-interaction<sup>109</sup>. The social constructionist perspective recognises the role of discourse in knowing (Berger & Luckmann, 1966). As discussed in chapter 3, Foucault's (1970) understanding of discourse as a set of rules or constraints that make certain statements, and not others, possible in particular historical, social, and institutional contexts. Under such an understanding it becomes apparent that the dominance of rural health education by a generalist health professional discourse in undergraduate nursing, medical and pharmacy programs, constrains its objective as a rural health workforce supply strategy. So in the practice of rural health education academics, rural health practitioners and students find themselves struggling to make sense of concepts such as rural people, places and practice because the body of knowledge known as rural health is ill defined and open to interpretation. Such dominance is ideological and ideology is an effect of power.

### **The study of effects of power and ideology in the everyday practice of rural health education through a critical perspective**

The practice of rural health education by health science academics, rural health practitioners and students is shaped by the internalisation of the social order of their academic or professional institutions. The third strength of this

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<sup>109</sup> See page [1633](#) for the discussion about socialisation-as-interaction.

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study was the ability to show how subtle forms of governmentality<sup>110</sup> (Foucault, 1979) and disciplinary power<sup>111</sup> makes rural health ‘knowledge’ a form of power. Because power exists and comes from everywhere it can work as a strategy that has the potential to subtly shape another's behaviour by producing certain ‘rituals of truth’ (Foucault, 1979, p 194). Under these understandings it becomes apparent how ill defined knowledge of rural difference and rural disadvantage, as uncritically accepted ‘truths’ in rural health education, have become episteme for understanding the rural condition. These powerful conditions for knowing rurality are beneficial for attracting scarce resources to rural communities. Nevertheless, ,making other effects of power and ideology visible in this study suggests these constructions are influencing the way students shape their identities in ways that may be less valuable for attracting them to the rural health workforce.

**The study of identity as an outcome of the socialising process of rural health education**

The fourth strength of this study was the way it outlined a new way of examining student identity as an immediate outcome of rural health education. Recruiting students to rural practice is, among other things, contingent on the way they experience rural health education and shape their personal and

<sup>110</sup> See pages ~~143~~ and ~~473~~ for discussions about the concept of governmentality.

<sup>111</sup> See pages for discussions about the concept of disciplinary power ~~163, 303, 403, 473,~~  
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professional identities. Identity is a fundamental influence on students' decisions to work rurally, and yet the field of rural health has not incorporated new ideas about identity that health science education already has to some extent (Cohen, 1981; DuToit, 1995; Niemi, 1997; Ohlen, 1998). Identity is shaped through relations of power and discourse that circulate in education. With some shifts in the practice of rural health education it may be possible to influence the way students shape their personal and professional identities in ways that may be conducive to rural workforce recruitment. In order to do this, the concepts and constructs of rural health education require some work to provide the field with alternative discourses to those of rural deficit that currently prevail within the pedagogical space. Furthermore, the curriculum would have to address issues that go beyond relying on experiential rural placements alone; it would have to include environmental, cultural and social components to build a new conceptual framework of best practice.

**The proposed use of rural health education as a way of achieving emancipation through the use of critical and reflexive perspective in its pedagogical work**

Through a focus on the relations of power, discourse and identity this research identified a hidden curriculum in rural health education that constructs rurality as a harsh, dangerous, sub intelligent backwater. It is a curriculum that has a set of implicit messages relating to knowledge, values, norms of behaviour and attitudes that the students experienced in and through rural

health educational processes. It was through the unintended meanings inherent in the language used in rural health education that the hidden curriculum reproduced cultural attitudes that exist in society and reinforce the relations of rural difference and disadvantage. Nevertheless, it may be possible to build strategies into rural health education to disrupt, rather than sustain, this hidden curriculum.

Educational approaches that are concerned with the development of reflexivity (hooks, 1994; Schon, 1983, 1991) would support academics, rural health practitioners and students' epistemological access to the enabling discourses for rural health. Further, educational approaches that are concerned with the development of critical perspective (Brookfield, 1987) would allow individuals to become aware of the explicit and implicit rules, values and assumptions that shape their ways of knowing. From this critical perspective emancipation can be achieved by giving individuals greater knowledge and control over their use of language. In this way, academics, rural health practitioners and students could act as 'critical or transformative intellectuals' (Skelton, 1997) who disrupt, rather than reproduce, the current epistemological understandings of rural people, places and practice. In this way, the diversity of rural people, places and practice could be spoken about in ways that empower and enable individuals rather than sustain the marginalisation of rural people, places and practice.

## LIMITATIONS OF THE STUDY

The findings in this study suggest the concepts and constructs that underpin rural health education require more work to develop a body of knowledge known as rural health. Further studies of the way people who live in rural areas understand their context and cultural systems may allow researchers and educationalists to develop these concepts and constructs in ways that are theoretically informed and based on evidence. The adoption of these suggestions would go some way to incorporating alternative discourses to those of disabling notions of rural difference and disadvantage. Exposure of educationalists and researchers to the theoretical perspectives that have underpinned this study (critical perspective, social constructionism and reflective practice) may also, over time, disrupt the hidden curriculum that currently exists in rural health education.

The contribution of this study may best lie in problematising the construct of rural health education and examining the effects of power in its everyday practice in nursing, medical and pharmacy education. The findings may be useful for informing a pedagogic approach to the education of undergraduate nursing, medical and pharmacy students about rural health. It is important to acknowledge the study provided an illustrative account of the day-to-day practice of rural health education by localising it to small groups of students, in one rural community, and at one University. These meaningful and contextual descriptions and interpretations of rural health education in practice offer the field new knowledge. The research framework developed in this

research offers the field a new way for generating such knowledge. At the same time, such a small scale study is clearly far from generalisable.

The findings of this study do not tell much about what happens in rural health education elsewhere in Australia. The literature review clearly shows that some models of rural health education strive to work towards improving rural community development through building infrastructure, building local expertise and developing rural centres of excellence in health care and education. It is important to emphasise that the Rural Clinical School in this state is working toward achieving these very goals and this was not the context in which this study was situated. Instead, this study examined the processes of rural health education that were being implemented within the broader undergraduate nursing, medical and pharmacy programs. The findings of this study have generated important insights that the Schools of Nursing, Medicine and Pharmacy could use to reconsider how they are responding to rural health issues within the undergraduate curriculum. The thesis shows that other universities and schools (Hays, 2001b; Hays et al., 1996; Hays et al., 1993; Hays et al., 1994; Murphy et al., 1994; Worley et al., 2000) have developed more rurally-immersed models that adopt of more proactive approach to helping students integrate theory and practice experiences rather than simply relying on rural locations as contexts for generalist learning experiences. Commentators (Hays, 2006; Worley et al., 2004b; Worley et al., 2000) from these schools have argued strongly that undergraduate initiatives on their own are insufficient for addressing the rural



workforce shortages in Australia.

The purpose of the study was to describe and interpret how academics, health professionals and undergraduate nursing, pharmacy and medical students produce and made sense of different social semiotic meanings in rural health education and consider how students' identities were shaped by these influences. Further research is required to identify alternative discourses for enabling rural health education and assessing whether other models of rural health education are harbouring a hidden curriculum. The conceptual and analytic framework and step-by-step description of the research methods and procedures presented in this study make it practically viable among larger numbers and in other contexts. Until the field generates further understanding of the effects of power and discourse in rural health education it will be difficult to assess how its underlying principles can be implemented to better effect improved rural health workforce supply.

#### FUTURE DIRECTIONS AND RECOMMENDATIONS

Can anything be learned from an examination of the presence of a hidden curriculum and the practice of rural health education in undergraduate nursing, pharmacy and medical programs? Is a theoretical analysis useful for changing what goes on in the power arrangements of rural health education? In this section the constructionist-critical tradition is maintained to further explore these aspects with a view to suggesting alternative relationships through three recommendations.

**Recommendation 1.** There needs to be more open and critical dialogue about the relations of power and discourse in rural health education at a theoretical level and a more vigorous attention to and discussion of the attitudes, language use and behaviours with students, academics and health professionals at a faculty level.

**Recommendation 2.** The foundational constructs and concepts, such as rural health and rural place, need to be theoretically developed for guiding health science educators in the development and implementation of rural health curricula in the undergraduate nursing, medical and pharmacy programs.

**Recommendation 3.** It is time for rural health education to be empirically informed and theoretically developed. In particular, educational, socialisation, power, discourse and identity theories have the potential for developing rural health education as rigorous and quality platform for teaching and learning about rural health.

**Recommendation 4.** It might be time to reconsider the Commonwealth funding schemes that are available to schools of medicine and pharmacy that include rural health education in their undergraduate program.

First, there is a need for greater equity between the disciplines for schools eligibility to the Commonwealth funding schemes for rural health education. Schools of nursing do not qualify for the same level of funding that is available for Schools of Pharmacy and Medicine.

Second, tighter funding criteria could be developed that requires schools of nursing, medicine and pharmacy to provide deeper learning approaches that intergrate theory and rural experience to more deeply ingrain rural culture and values in undergraduate curricula. The funding could be targeted at fewer schools who are committed to developing and implementing comprehensive models of rural health education that extend beyond rural workforce recruitment or generalist learning experiences. This would make it possible to better address the workload, and preparation and support of university teaching staff and rural health professionals who contribute to rural health education through preceptorship to be addressed.

From this study emerge a number of directions for further research. Recommendations for further study of rural health education include:

- research that seeks to identify how people who live in rural and remote Australia understand their belief and value systems. These understandings may provide alternative discourses for enabling rural health education;
- research that seeks to examine how discourses might be influencing students learning experiences and future career intentions;
- research that assesses whether other models of rural health education may be harbouring a hidden curriculum, and if so, what meanings it sustains in academics, rural health practitioners and students talk during

rural health education;

- research that assesses whether the research framework developed in this study is practically viable among larger numbers of participants and in other contexts, and
- research into the changing nature of socialising process of rural health education and the study of students' identity as an immediate outcome.

One of the most persistent characteristics of the rural health landscape is the disparate arrangement and relative shortage of health care professionals. In response, the Australian Commonwealth government has invested heavily in the development of, and investment in infrastructure and education initiatives over the past decade. The primary goal of these initiatives is to raise students' awareness of rural health issues and generating their interest in a rural career. There are significant costs associated with rural health education, and they require a high degree of commitment from academics, health practitioners and students to ensure these are high quality models of best practice.

If rural health education outcomes do not adequately work to attract future graduates to rural practice, similar levels of funding may not be forthcoming from the Australian government. These are significant and important concerns within the field of rural health. At the same time, this research has generated findings that draw attention to other important issues that

have significance for the future sustainability of rural health education. These relate to the quality of rural health education, both as a rural health workforce supply strategy, and also as a component of generalist core curriculum in health science education. If universities continue to use rural health care agencies to provide ever increasing numbers of students with clinical practice experiences, better education support initiatives must be implemented.

Despite their willingness to be involved in health science education, rural health practitioners are too busy, too under staffed and too under resourced to adequately provide optimal professional learning experiences to students. Meeting the dual demands of busy workloads and enlightening students about ethical, patient-centred and holistic approaches to care is challenging for any health professional (Charnley, 1999; Forrest et al., 1996) . In the rural context, where busyness has become normalised, these ideals tend to be lost in favour for more task oriented and technical approaches to practice. The quality of education cannot be guaranteed in a system where there is not enough staff to provide students with ongoing clinical supervision. It seems that rural health practitioners, in their roles as clinical supervisors to students, require empowerment and support from sending universities. Only then will they be sufficiently equipped to develop professionally in ways that ensure students learn about professional practice in patient-centred and holistic ways.

As a rural health workforce strategy, the possibilities for rural health education to evolve, develop and mature are endless. The findings in

this study suggest that health science academics are willing to include rural health content in their teaching and learning activities. While this is encouraging, there is a critical need for rural health educationalists and researchers to explicitly develop the enabling concepts and constructs that form the basis of rural health teaching and learning in health science education. Ideally, all rural health education should be based on a strong evidence to develop theoretically informed, 'well-designed, long-term and intensive curricula' (Ranmuthugala et al., 2007). All rural health education, whether a topic area in a generalist core curriculum or a targeted, intensive rural training program will benefit from a shift away from the current emphasis on disabling rural discourses that tend to represent rurality in terms of deficit. The findings of this study suggest discourses of rural deficit are negatively impacting upon the way students shape their personal and professional identities. In turn, these identity formations underpin students' reluctance to take up rural practice as a future career option.

Rural health education has been hailed by educationalists, policy makers and researchers as the panacea for addressing the rural health workforce shortages by increasing the supply of new graduates who are willing to take up rural practice. With greater emphasis on critical analysis and reflective practice in both education and research practices it may be possible for rural health education to achieve this outcome. Critical and reflective perspective is required at all levels, and across all disciplines, to systematically improve aspects of the rural experience by disrupting disabling discourses. Not only will this work to

create a positive impact on undergraduate medical, pharmacy and medical students, it may begin to make some inroads into disrupting the marginalising conditions for rural populations. Further, methodologically rigorous studies of the practice and outcomes of rural health education will help provide the information necessary to examine rural exposure in terms of addressing the undersupply of the health workforce in rural Australia.

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## APPENDICES

### APPENDIX 1. HUMAN ETHICS APPROVAL

Dear Dr Bull

Ethics Ref No: H7786

Project title: Undergraduate rural placements: Discourse and the emerging health science professional.

This email is to confirm that your Progress Report was approved by the Human Research Ethics Committee [...] Network on 21/3/2005.

Your next report is due on 5/4/2006. A reminder email will be sent prior to the next due date.

If your project is completed before the date shown above, a FINAL REPORT must be forwarded to us as soon as possible.

It is not standard policy to send a hard copy confirmation of the report approval. Please let us know if your circumstances require a letter of report approval.

Should you have any queries please do not hesitate to contact me.

Kind regards

[ ]

## APPENDIX B. INFORMED CONSENT DOCUMENTATION

### *(I) EXTRACT FROM INFORMATION SHEET ABOUT THE RESEARCH PROJECT*

#### **Purpose of the study**

We would like to invite your participation in a research study. The purpose of this research is to unravel the various influences that impact upon your experience of rural health education. The study is being undertaken to fulfil the requirements for a PhD degree by Lisa Dalton.

#### **Participant Benefit**

The study will offer you the opportunity to explore and reflect on your engagement in rural health education. This process will allow you to gain new insights into your practice and development as a future nurse, doctor or pharmacist. It will provide you with the opportunity to discuss issues that arise during the rural placement experience with students from other disciplines, as well as your own. You may find these discussions helpful in making your career decisions.

#### **Inclusion and Exclusion Criteria**

The study is concerned with examining the rural placements that undergraduate nursing, pharmacy and medical students are undertaking at the University [ ]. For this reason to be included in this study you must:

- be an undergraduate student of nursing, pharmacy or medicine,
- be about to enter a rural health care setting for the next clinical practice rotation,
- be enrolled in one of the following undergraduate units:
  - [ ...]

#### **Study procedures**

If you agree to be involved with this study you will be asked to sign a written consent form. Lisa Dalton will be staying at [...] during your rural placement. Should you agree to participate in the study, you will be observed in this setting, the health care agency and while you engage with the broader rural community, at intervals over a two-week period. While you may be observed in the clinical practice setting, this will not occur where direct patient care or interaction is involved.

You may be invited to attend a one-hour (maximum) semi-structured interview where you will be asked to explore your rural placement experience. With your permission, the interview will be audio taped and transcribed. Following the

interview you will be provided a copy of the transcript and outline of the themes and issues that emerged in analysis. You have the right with withdraw any aspect of the data without penalty.

### **Payment to subjects**

There will be no monetary, or other reward, or remuneration offered to participants.

### **Possible Risks**

No risks are anticipated with participation in this study. These activities are not expected to impinge on your time in clinical practice. Should you require, there will be opportunity for a study debriefing at the completion of the rural clinical practice. **This study is in no way related to your academic or clinical practice performance report, assessment or evaluation. Your participation or non-participation will have no effect on your overall course assessment.**

### **Confidentiality**

Only information that you feel is appropriate to the discussion, and that you are comfortable to disclose, will be sought. All data collected is confidential, and you are free to withdraw personally from this study and/or withdraw any of your data any time without prejudice.

Anonymity for participants and fieldwork sites will be maintained through the use of identification concealment measures such as the use of pseudo-names, in the transcripts and the thesis,. Audiotapes and interview transcripts will be maintained in a locked filing cabinet at [...]. In line with the NHMRC Guidelines, audiotapes and transcripts will be kept for five years following the completion of the study and then be destroyed.

### **Freedom to refuse or withdraw**

You have the right with withdraw any aspect of the data, or from the study in entirety without explanation or penalty.

### **Who do I contact if I have any concerns of an ethical nature, or complaints about the manner in which the project is conducted?**

This study has received ethical approval from the Human Research Ethics Committee [...] Network.

If you have any concerns of an ethical nature or complaints about the manner in which the project is conducted, you may contact the Executive Officer of the Human Research Ethics Committee [...] Network. The Executive Officer can direct you to the relevant Chair of the committee that reviewed the research:

[...]

If you have any personal concerns related to the study, you may choose to discuss these concerns confidentially with a University Student Counsellor free-of-charge.

## *(II) STATEMENT OF INFORMED CONSENT*

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1. I have read and understood the 'Information Sheet' for this study.
  2. The nature and possible effects of the study have been explained to me.
  3. I understand that the study involves the following procedures:
    - being observed in the accommodation setting.
    - being observed in some clinical practice settings.
    - being observed in the broader rural community
    - participation in a one-hour (maximum) semi-structured interview
  4. I understand that no risks are anticipated with participation in this study and it is anticipated these activities will not impinge on my time in clinical practice. There will be an opportunity for debriefing about participating in the study at the completion of the rural clinical practice should I require this. I understand that this study is in no way related to my academic or clinical practice performance report, assessment or evaluation.
  5. I understand that all research data will be securely stored on the University [ ] premises for a period of 5 years at the end of which the data will be destroyed.
  6. Any questions that I have asked have been answered to my satisfaction.
  7. I agree that research data gathered for the study may be published (provided that I cannot be identified as a participant).\*
  8. I understand that my identity will be kept confidential and that any information I supply to the researcher(s) will be used only for the purposes of the research.
-

9. I agree to participate in this investigation and understand that I may withdraw at any time without any effect, and if I so wish, may request that any personal data gathered be withdrawn from the research.

Name of participant \_\_\_\_\_

Signature of participant \_\_\_\_\_ Date \_\_\_\_\_

10. I have explained this project and the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation.

Name of investigator \_\_\_\_\_

Signature of investigator \_\_\_\_\_

## APPENDIX C. SAMPLE EXTRACTS FROM UNCODED FIELD NOTES

### Pharmacy Students Day 4 14.04.05 2.10 – 3.00 pm Observation-of-participation: Wing tour

589. C: Hello there . I have got the pharmacy students here for you and turns back to smile at them .

A nurse emerges and stands inside the doorway of the office. The students turn their heads and smile at her.

590. N: [Smiles] . right. I'm not sure what to do with you to be honest stares at the students] .

Bronwyn steps forward to face the nurse and then turns and raises her eyebrows at Sarah.

591. S: [sighs giggles and shrugs her shoulders at Bronwyn]

592. B: [shaking her head at the nurse] . well the purpose of the rural plac[

593. N: [what would you like to do?

594. B: well - look at a few a drug charts . when we went the nursing home we started with a quick tour and then .

595. N: yep . I can do that [looks back into the office] .  
I'll just finish what I was doing [turns and walks back into the office]

The students stand in the corridor and watch as the nurse picks up a folder from the desk and hands it to another nurse.

596. N: I have done  
Nelly's, Gwen's and Bob's but I haven't started this one yet [turns back and walks out

- into the corridor to face the students] . right then how long are you here for?
597. B: [looks at her  
watch and up to the nurse] . til 5 oclock [glances back at Sarah and smirks] . unless  
you have no need for us . I mean it's no good us to[
598. N: [oh okay . well between 4.30 and 5.00  
we do BSL's and subcuts so you can week those .
599. S: Oh that would be great [meekly]

The nurse proceeds to walk along the corridor with the students following she stops at a set of heavy double fire doors. The students stand and look at the closed doors.

600. N: well this is physio  
[students look toward a closed wooden door the nurse points to] and behind there  
[students look at the heavy closed fire doors] is the hospital side and this is our side .  
and in here [students follow the nurse as she walks to a glassed door] is the new  
section [students look at a picture hanging on a freshly painted wall the nurse waves  
at] . that's why its got nice new colours . anyway you can get the gist of what the new  
section will be like in the upgrade .

## APPENDIX E. EXTRACTS FROM SOLICITED AND UNSOLICITED FIELD INTERVIEWS

### *(I) EXTRACT FROM UNSOLICITED FIELD INTERVIEW*

1059. E: I am just totally blown away by how busy we are on the wards . I imagined myself talking with the patients and making them feel better . I am so preoccupied with keeping up with the nurses that I hardly have enough time to say hello to a patient . I did some wound care today . that was really exciting

1060. L: Did you?

1061. E; [nods]

1062. L: Did you use the wound field or the cross over technique?

1063. E: I did the wound field technique -

1064. L: Oh really

1065. E: Well .

[rolls her eyes] they didn't like it -

1066. L: Oh . they didn't like how you approached the dressing?

1067. E: No . they didn't like me doing the dressing .  
they haven't let us do anything -
1068. L: What do you mean?
1069. E: All we have done  
since Monday is observe . and study the patients conditions . all we hear is that they  
are not legally allowed to let us do anything so all we can do is watch . like today I  
was observing a lady being showered and at the end the carer says can you get me  
a towel and I said yeah no worries where do I find one and she huffed and said I  
might as well get it myself but you cant stay here with the patient you will have to  
wait outside the door until I come back . I thought you cant be serious here is an  
elderly patient sitting in a commode chair all wet and you think it would be safer for  
me to wait outside of the room and leave them like that . like even if I didn't touch the  
patient at least just by being there I could help her . we were told at uni that we could  
do stuff like that
1070. L: or ring the buzzer if something did happen
1071. E: that's  
right . that exactly right . they wont let us do anything . and we are allowed to do  
everything the RN does with their supervision . its been really boring and I feel like  
we are not learning anything because we are not allowed to do anything . the others  
are doing heaps giving injections, showering and dressings and things -

(II) *EXTRACT FROM SOLICITED FIELD INTERVIEW*

2741. L; Hello there – how has your week been?
2742. T: oh his been okay I guess . we  
went to the nursing home this week
2743. L; how did that go?
2744. T: well it has made me re-evaluate my  
views on euthanasia
2745. L: do you mean pro or ante euthanasia?
2746. T: pro . I mean if I was old and  
demented and screaming out I want out
2747. W: oh Turks you are the most catholic person in the  
whole world



2748. L:  
how would you reconcile your beliefs systems with your statement?
2749. T: what  
Catholicism and euthanasia?
2750. L: yes
2751. T; well they don't reconcile at all . simple
2752. L; so does that  
present some tension for you?
2753. T: yeah . it certainly gave me something to think about . it was certainly  
a big learning experience .

## APPENDIX F. SCREENSHOT OF CODED FIELD NOTE

Rural Health Education.nvp - NVivo

File Edit View Go Project Links Code Format Tools Window Help

New

Code At: Name learning the culture In

Normal Arial 10

Look for: Search In Documents Find Now Clear Options

Documents

Name	Nodes	References	Created	Modified
Different Life 10				
Want to go home 39				
Rebelling from practice 45				

what is done

1801. L: yeah . I suppose so . but did you notice when the carer kept going up to her and saying the pills are not here where are the pills and the nurse kept saying I'll take them down ... no don't worry I'll do it . that the carer didn't seem to mind

1802. E: yeah .. you're right . so why would she do it then

1803. L: I don't know but I will never ever do that . its just not worth it . my registration . I'm not going to risk it

1804. E: me either

1805. L: but I don't want to dob . I don't want to piss them off or anything . we just don't want to be dobbers . its just not worth it . we could just wait it out . its not that much longer . they could make our lives hell if we go on the wrong side of them .

1806. R: well one way of dealing with this is to think of it as a reflective learning experience

1807. L: what's that?

1808. R: " ... "

Coding Density

learning the culture

renaming the culture

surviving the culture

4 Items Nodes: 3 References: 8 Read-Only Line: 31 Column: 12